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THE DIAGNOSTIC AND THERAPEUTIC VALUE OF THE MEDICAL SOCIAL STUDY OF CASES*

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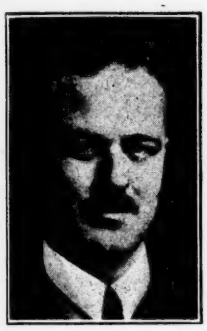

A hundred years ago in the "horse and buggy days" the old-fashioned family doctor's practice was largely limited to the members of his own community. As a result he knew more or less intimately the majority of his patients. Many of them were his close friends. He attended them during their confinements and assisted nature in the delivery of their children. He cared for those children during infancy, childhood and adolescence and was a guest at their weddings. He shared their joys and sorrows and knew their ambitions and disappointments. This doctor's medical education had been largely acquired through daily association with some older physician, in the visits from house to house, and his attitude toward illness was practical rather than scientific. His primary aim was more the health and happiness of the patient than the control or cure of disease, and the concept of prevention of disease was beyond his horizon. If judged by our modern standards, his knowledge of medicine was meagre, but he knew human nature and the personalities of the individuals with whom he was dealing and the application of this knowledge was one of his most valuable diagnostic and therapeutic assets.

Today, the young physician enters practice so embued with the knowledge of an ever increasing number of laboratory and mechanical aids to diagnosis and treatment that he is prone to regard his patients as "cases" rather than human beings. He has had little, if any, opportunity to see his patients in their homes, and he has not formed the habit of thinking of the relationship between their personal problems and their illnesses. Of course, modern teaching hospitals have medical social workers whose function it is to study and evaluate social aspects of medical cases, but as yet their work is not sufficiently integrated with that of the interne to make him realize that it is a vital part of medicine. Many house officers graduate from the hospital with the idea that the work of the Social Service Department is largely a charitable endeavor to better the lot of poor patients. They do not realize that the well-to-do have just as many and often more complicated social problems, and they do not appreciate that these problems frequently have a direct bearing upon the diagnosis and treatment of the patient's illness.

To attempt to diagnose or treat illness without consideration of the social elements in the patient's life is quite as unscientific and inaccurate as it would be to disregard

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the value of laboratory data. I make this statement after due consideration and I want to amplify it by citing two cases which illustrate just how social study may affect the diagnosis and treatment.

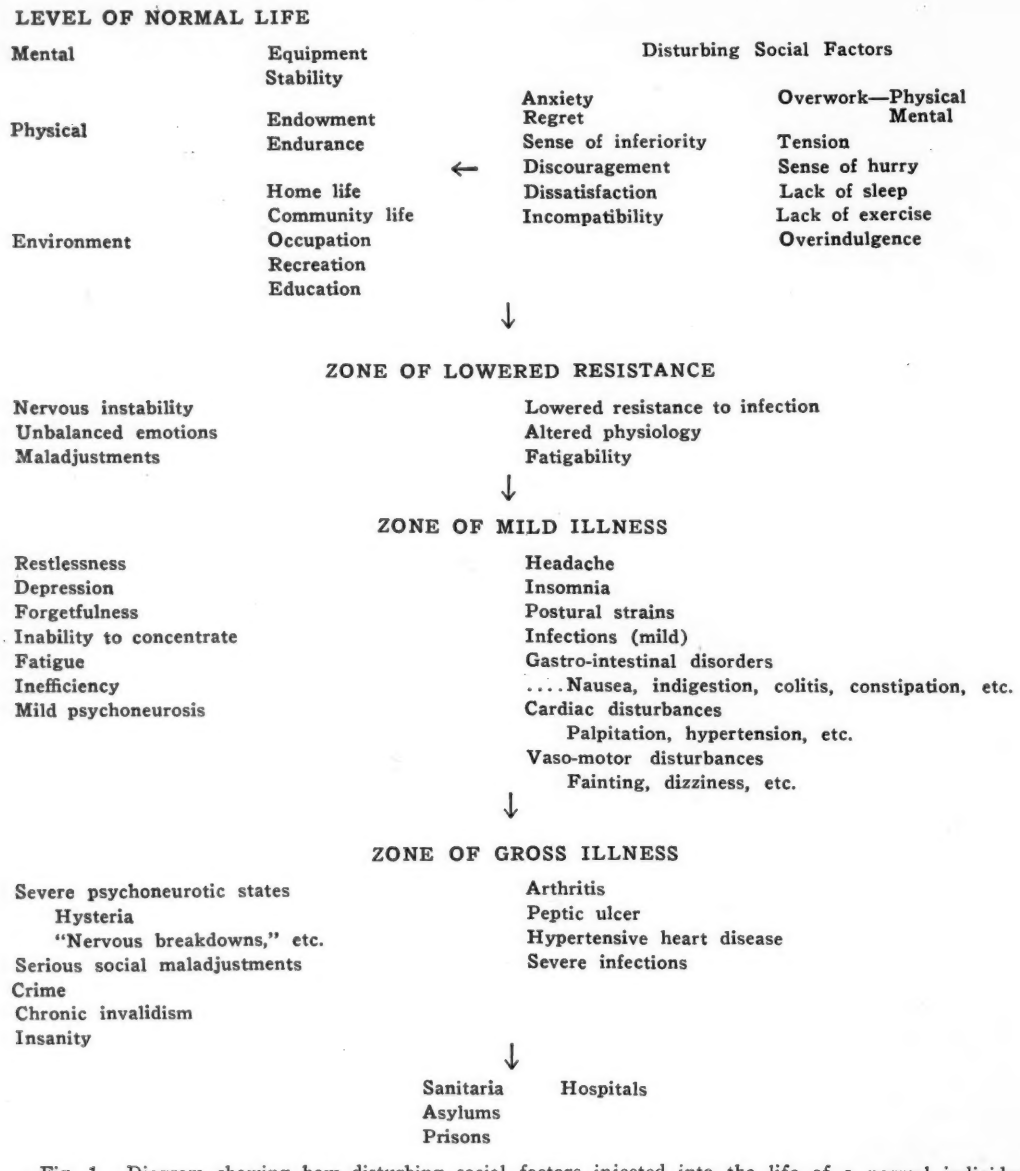

Fig. 1. Diagram showing how disturbing social factors injected into the life of a normal individual may lead to nervous or physical illness.

Diagnosis

Case 1.—A physician was called one evening to see a new patient. The history as given over the telephone by the patient's mother was that her daughter had been perfectly well until after supper, when she complained of a severe headache and went to bed. An hour later the mother, on going to her daughter's room, found her lying in bed with flushed face, moaning and tossing about, but semi-stuporous and incoherent. The physician suggested immediate hospitalization, but as this was refused he went to the home, to which he was admitted by the mother. Further questioning of her failed to reveal any significant data. The patient had had no previous illnesses, her husband and one daughter aged six were living and well and the household consisted of these two, the patient, her mother and one servant. The mother, however, was the only one seen by the physician. Therefore, after a brief interview he went upstairs to examine the patient.

Physical examination revealed a temperature of 102° F., flushed face, restlessness, semi-coma, acute pharyngitis, a suggestion of left lateral nystagmus, a stiff neck held rigidly in hyperextension, and hyperactive reflexes. The remainder of the routine examination was negative.

The physician told the patient's mother that he believed her daughter had meningitis and that a lumbar puncture was necessary to confirm the diagnosis. Just as this was to be done the patient's husband strolled nonchalantly into the room smoking a cigar. A single glance revealed the fact that

he was at least twice the patient's age and from his cold and disdainful expression it was evident that he had no great affection for his wife. As he stood by the bedside looking down at her, his hands in his pockets, his cigar in his mouth, the patient, who you will remember had appeared semi-stuporous,

Treatment

The next case is an excellent example of the value of social study and planning to the treatment of a patient.

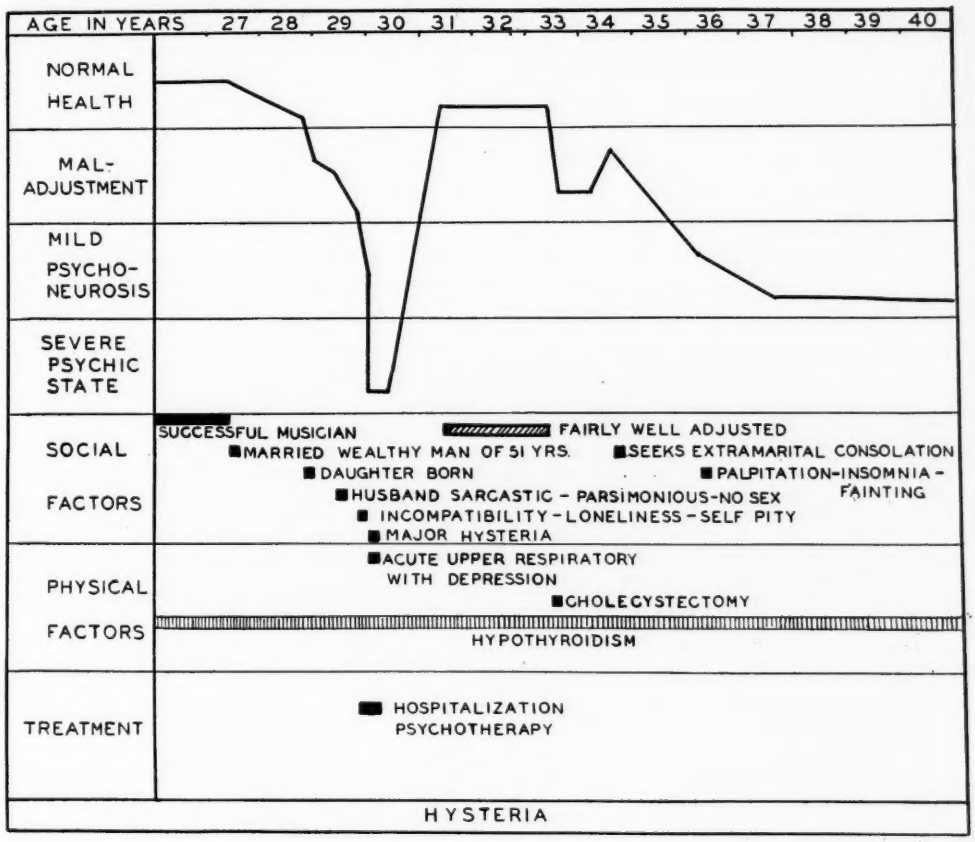

Fig. 2. Graphic representation of Case 1 in text.

opened her eyes, and, seeing him, held out her arms in a dramatic gesture of appeal. He continued to gaze scornfully down at her for a few seconds, then slowly his hand went up to his cigar and removing it from his mouth he blew a huge cloud of smoke at her and sauntered out of the room without a word. The patient burst into tears and the physician put away his lumbar puncture needle. Hysteria now seemed the most likely diagnosis and a few minutes later, when she had quieted down, the physician was able to elicit a story of extreme marital discord, mental cruelty and absence of sexual relation since the first year of marriage which confirmed the diagnosis. The fever was explained on the basis of an acute upper respiratory infection and the stiff neck and nystagmus disappeared with the emotional relief of telling her story. Had this patient been seen only in the hospital and without an opportunity to observe the husband in the patient's room the correct diagnosis would have been missed, at least until a negative lumbar puncture and the course of her illness had ruled out the possibility of a meningeal infection. Thus, the simplest form of social study, mere observation of a few minutes of domestic relations, contributed to diagnosis.

Case 2.—A well-to-do married woman of forty-five years was suffering from rather severe rheumatoid arthritis. The diagnosis was obvious and a careful physical examination and laboratory study revealed no complicating factors, other than rather extreme fatigue. Therefore, she was put on a regime of treatment which consisted of dietary regulation, proper bowel management, physiotherapy, bed rest at home, and appropriate medication for the relief of joint pains and insomnia. Weeks went by with no improvement in the condition of the joints nor did the patient seem to be any less tired despite the fact that she remained constantly in bed, was eating properly and sleeping well. The situation was, to say the least, discouraging both to the physician and to the patient, and finally a consultant was called. To him the outstanding feature of the situation was that fatigue had not been relieved by prolonged physical rest under what at first glance seemed to be ideal conditions, and he, therefore, directed his attention to a more thorough investigation of the minute details of her daily routine. He found nothing to criticize in her physical surroundings. She was in a comfortable bed in her own room which overlooked her garden, but which was sufficiently removed from the noises and activities of the rest of the household to be

quiet and restful. There was no evidence of lack of coöperation on the part of the patient nor of her family, and the diet was carefully supervised. A detailed history of just how the patient had passed each hour during the preceding week, however, revealed a great deal of mental activity and nervous tension. Although lying in bed, the patient had had

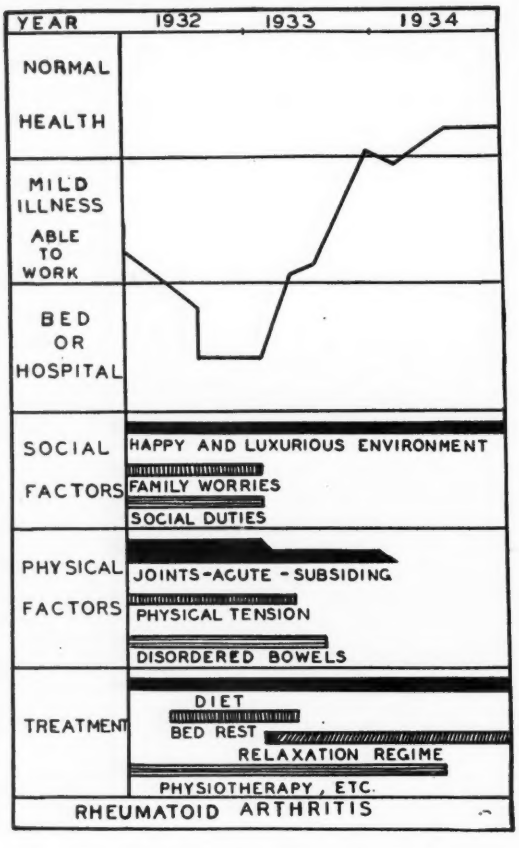

Fig. 3. Graphic representation of Case 2 in text.

many and complicated matters to deal with. There had been daily interviews with servants in regard to housekeeping, she had considered every detail of the administration of the estate and she had held many meetings of committees in relation to various charities in which she was deeply interested. She had discussed at length the problems of her elder daughter's health with a physician and had worried greatly over the general behavior and attitude of her younger daughter. And she had made a great effort each day to be cheerful and entertaining when her husband came home from business. There were many visitors, endless telephone calls and much correspondence both of a personal and business nature to be attended to each day. These activities were not to her drudgery or work, but a pleasant part of life, and she expressed herself as thankful that she was able to accomplish so much and, at the same time, "to be resting so completely all day and all night." Actually, she had had scarcely a moment in which to relax, and had therefore remained at a high degree of nervous tension and of fatigue. With proper reorganization of her life her total daily activity was greatly curtailed but not so strictly as to make her feel out of things. Most of the administrative duties were delegated to other members of the family, the number of committee meetings taking place in her bedroom reduced, and it was arranged that visitors and telephone calls would not reach her during certain periods set aside for complete rest. The anxiety about her two daughters was relieved by a more thorough investigation of the physical health of one and putting the other in the hands of an understanding psychiatrist who found her problem to be a simple one. Her husband read aloud to her in the evenings, which obviated the necessity of her entertaining him. Under these modifications of her regime she slowly became more relaxed and rested, her general condition steadily improved and her arthritis gradually became quiescent.

Prevention

Now let us consider what part social study may play in the prevention of illness. One aspect is so obvious that it requires only the briefest mention. The physician's duty in the case of a patient with an infectious disease such as tuberculosis does not end with the treatment of the individual. He must make every effort to locate and examine others who may have been infected through contact with the patient. It is evident that the first step in this endeavor is to acquire an exact knowledge of the social relationships of the patient not only in his family but among others with whom he is in daily contact.

But social planning also plays an important part in other aspects of the prevention of illness. The individual who has been permanently physically handicapped as the result of some disease may be able to lead a normal useful and happy life if his activities and pursuits are so planned that they are not incompatible with his physical limitations. The adult with a damaged heart must be taught how to live as normal a life as is consistent with his cardiac restrictions. The child who has mitral stenosis should be guided in the selection of a vocation which does not entail too much physical exertion. The dangers of psychological maladjustment in a crippled child may be avoided by so planning his education that he fits himself for a position in life where that limitation is the least possible handicap. Peptic ulcer and diabetes are other diseases in which education of the patient and planning of the daily routine will aid in preventing relapses. It is easy to get the urine of the patient with diabetes sugar-free and to relieve the ulcer patient of his pain while under intensive treatment, but it is frequently difficult to keep either of them well when they return to work.

Convalescent Care

The construction of a program for convalescent care in these two conditions, and indeed in all serious illnesses, is of vital importance. The weakest point in the treatment of patients today is the instructions which they receive at the time of their discharge. This is especially true in the public hospital where such advice is given usually by a comparatively inexperienced interne, but is it not also a just criticism of our attitude toward the private patient who is recuperating from an illness and to whom we are paying a few final and often hurried visits? Are we not apt to tell him to "take things easily for a few weeks more" or to give some equally vague and indefinite advice? The patient, during his illness, has turned over the management of his daily routine to his physician, and he has been encouraged to forget as far as possible his responsibilities in life. Just at the moment when he is beginning to increase his activity and to face again these responsibilities, he is expected to take over, at least to a large extent, the care of his health. Certainly, he needs, at this time, the most careful and detailed advice that can be given. The physician should plan with him each step in the return to his normal life and should point out as far as possible the things to be avoided as well as the rules to be observed. The patient should not be expected to realize just what is liable to prove too much for him nor to distinguish which portions of his treatment are absolutely necessary and which merely desirable. When his normal activities conflict with the details of his convalescent regime the doctor, not the patient, should decide which is the more important. Unless this is done and the inevitable compromises between ideal and practical treatment made, the patient is liable to err too much either in one direction or the other according to his temperament. The more complete his understanding of his situation the more successful will be his management of his own convalescence.

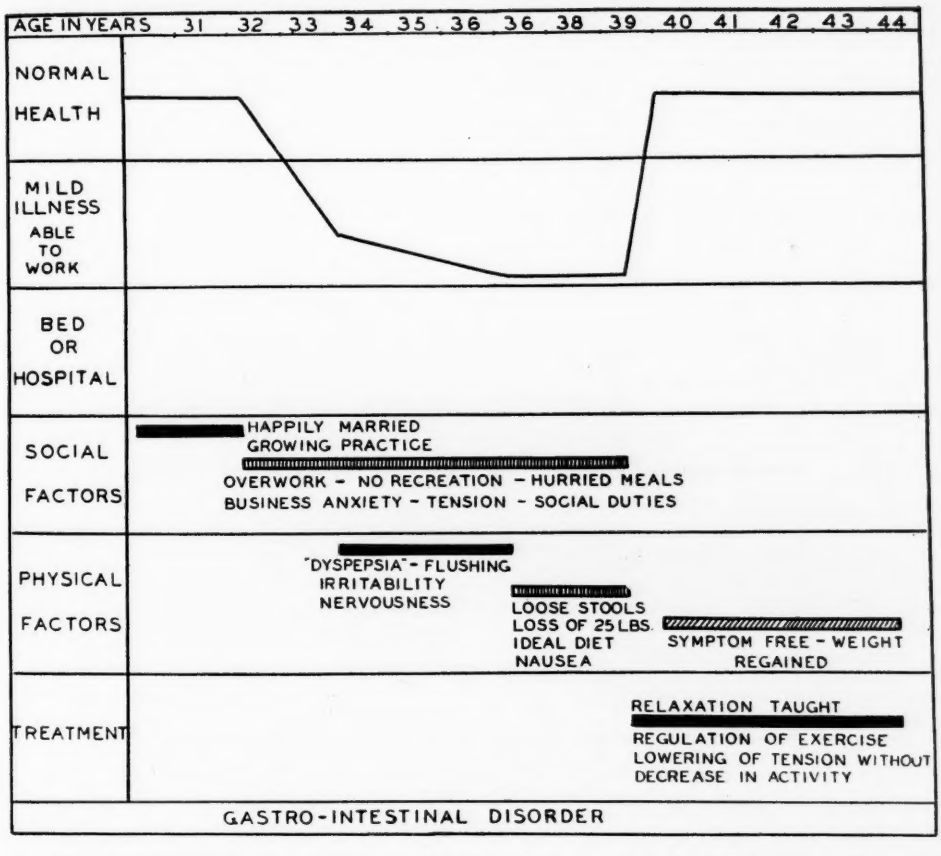

Fig. 4. Chart illustrating the relationship of social factors and physical factors to the course and treatment of a gastro-intestinal disturbance.

Thus, we see that the social study is in reality an important part of the physician's

duty, a vital factor in his struggle against illness. In public hospitals the accumulation of this data has been, in large part, delegated to highly trained specialists — the social workers—who, through their experience and service has been established for seven years and has unquestionably proved its worth. I am delighted to learn that in the State of Michigan the Committee on Health Activities of the McGregor Fund has estab-

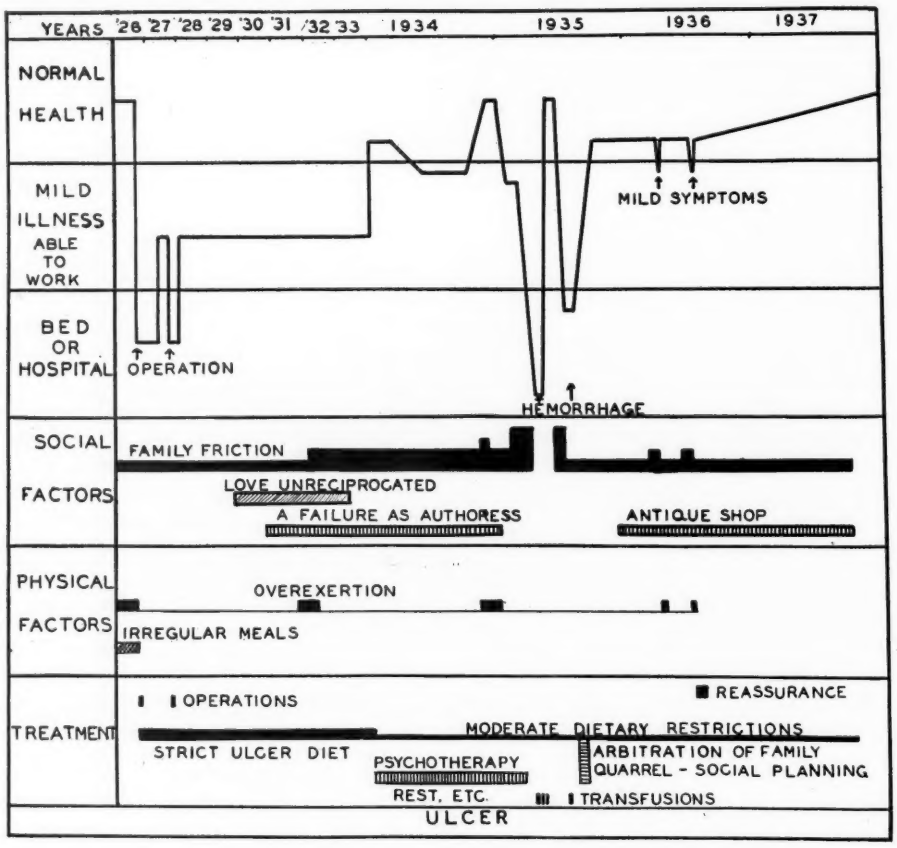

Fig. 5. Graphic representation of the apparent relationship between social planning and the relief of symptoms in a young woman with peptic ulcer.

study, have learned the best methods of acquiring the information necessary and of applying it and the resources of the community to the needs of individual patients. But, even in the public wards, the physician should supervise the investigations of the social worker and correlate her findings with the medical aspects of the patient's illness.

The physician still has to elicit and evaluate the social factors in the problems of his private patients. But the day may not be far distant when medical social service will be available to the physician in his practice. Certain steps in this direction have already been made. At the Baker Memorial Hospital, a department of the Massachusetts General Hospital devoted to the care of patients of moderate means, medical social service has been established for seven years and has unquestionably proved its worth. I am delighted to learn that in the State of Michigan the Committee on Health Activities of the McGregor Fund has established a program of medical social service for the private patients of the physicians in Detroit. This is an interesting experiment and one which should prove of great value. But I want to point out that social study and evaluation was originally a function of the physician, that, while in hospitals it has been delegated to special workers, it remains a function of the physician, and that the integration of the social factors with the medical component of the case must be done by the physician. The rôle of the medical social worker is that of a consultant in a special field who makes a certain type of examination and then offers advice, not that of a specialist who is equipped by education and experience to assume the responsibility for the care of the patient.

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EXAMINATION OF THE CERVIX UTERI*

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In this paper, I propose to discuss the importance of examining the cervix of the uterus under three divisions: first, as a part of a routine in pelvic examinations; second, following every obstetrical delivery; third, as a routine procedure prior to gynecological operations.

Routine in Pelvic Examinations

It hardly seems necessary to say that a careful examination of the cervix should be a part of every pelvic examination, yet a large number of cervices, showing important pathology, escape the eye of the attending physician. Although the sense of touch is highly developed in many physicians, it cannot replace visualization of the cervix. Deep lacerations, scar tissue, retention cysts, large polypi and malignant induration when extensive can be felt, but erosions, endocervicitis, small soft polypi, and early malignancy are often missed when the cervix is not carefully inspected.

Inventive physicians and instrument makers have devised many types of lighted vaginal specula and tubular lights for illumination of the vagina, and though these instruments are useful, they are not essential. A pair of rubber gloves, the common bivalve speculum, and direct or indirect lighting are adequate equipment for thorough inspection of the cervix.

The most common lesions seen in the cervix are lacerations from labor, ectropion and erosion, endocervicitis, and polypi. Lacerations of the cervix occur in every first labor. They may be trivial, but even in normal labor there is a tendency toward rupture of the thin fibers of the cervix laterally so that varying depths of unilateral or bilateral tears are frequently seen. These will be discussed in more detail under the heading, examination of the cervix following delivery.

Injuries of the cervix lead to a prolapse or a rolling out of the normal columnar ciliated cervical epithelium so that it is exposed to the trauma, acid secretions, and infections of the vagina. The thin columnar epithelium appears as a bright red area of varying width surrounding the external os. The color is due to dilated capillaries in the connective tissue showing through this thin layer of columnar epithelium. In the presence of infection the normal squamous epithelium of the vaginal portion of the cervix becomes desquamated. Round celled infiltration occurs below the desquamated areas and ciliated cervical epithelium grows in to replace the lost squamous epithelium and to form many new cervical glands. However, as healing takes place, the squamous epithelium again invades the area covering the cervical epithelium and glands, finally healing the lesions. This metaplasia of epithelium of the cervix following laceration and infection is called ectropion and erosion.

The term "endocervicitis" is applied to infection of the glandular lining of the cervix. This is only seen in the acute stages of infection as the deeper glandular structures and tissue soon become involved, causing a cervicitis or generalized infection of the cervix. When acutely inflamed, the cervical mucous membrane becomes swollen and edematous and prolapses through the external os as a bright red surface covered with exudate. This discharge may be mucoid, or mucopurulent, or tinged with blood. In the chronic stage infiltration of the deeper supporting tissues takes place. The glands become enlarged. Their outlets are obstructend and retention cysts result. The cervix often becomes greatly enlarged. Thick, tenacious, mucopurulent cervical plugs fill the canal and cause sterility. Increased connective tissue and scars in the cervix undoubtedly cause dystocia. Not only is dilatation slow, but deep tears occur. The frequency of puerperal infections and febrile postpartum complications in multiparous women can often be traced to a lighting up of infection from a chronic cervicitis.

Physicians who constantly search for

*Read before the Upper Peninsula Medical Society, Houghton, Michigan, August 20, 1937.

focal infections often fail to examine the cervix. However, this organ is ideally constructed to harbor infection and women have been cured by cleaning up infection in the cervix not only of leukorrhea, dysmenorrhea, dyspareunia, menorrhagia, metrorrhagia, but of diseases in remote parts, such as iritis. Most cases of lumbar pain in women should be treated by the orthopedic surgeon but the physician who eradicates infection from the cervix will cure a surprisingly large number of women of this ailment.

Many cervical polypi are missed when bimanual examinations of the pelvis are made without inspection of the cervix. These tumors rarely become malignant, although carcinomatous and sarcomatous changes may occur in them. When well protected in the cervix, polypi show the characteristic red color of cervical mucous membrane. The pedicle is not seen. When the tumor extends outside the external os, squamous epithelium covers its surface and it has a paler appearance. Secondary changes, inflammation, torsion of the pedicle with resulting edema, hyperemia, and gangrene are often seen in polypi.

Routine Following Obstetric Delivery

Routine inspection of the cervix immediately following delivery has been recommended by several prominent obstetricians. This, I believe, is unnecessary. Immediate inspection of the cervix, unless carried out under aseptic conditions, would add to maternal morbidity and mortality. The appearance of the cervix immediately following delivery is often startling; small lacerations appear much larger than they are; edema distorts the cervix and small interstitial hemorrhages alter the appearance of the tissues. Six to eight weeks later, the same cervix is normal in size and contour, small lacerations are well healed, the edema has disappeared, and the color of the tissues is normal. Inspection of the cervix at this time gives a true picture of the residual damage after nature has completed its reparative processes.

When circumstances require operative procedures such as manual dilation of the cervix or forceps delivery through a cervix that is not completely dilated, or when bleeding continues from a clean, tightly contracted uterus, the cervix should be inspected immediately and repaired when necessary.

Involution of the puerperal cervix goes on for six to eight weeks following delivery. At the end of this time the cervix should be thoroughly inspected, for now much can be done to restore the cervix to its former condition. Glycerine tampons will dehydrate the tissues and lessen hypertrophy and edema; warm saline or boric acid douches daily will clean the cervix of exudate and hasten healing; puncture of occluded cervical glands with a small pointed cautery will care for cysts if not too numerous; the application of a larger blunt pointed cautery tip to unhealed infected ulcers and to erosions will hasten the covering of these areas with healthy squamous epithelium; when lateral tears of the cervix allow a marked eversion of cervical epithelium, deeper linear cauterizations will contract and tend to restore the former shape of the cervix, putting the cervical epithelium back into its protected position in the cervical canal. Leukorrhea, memorrhagia, metrorrhagia, and backaches are relieved by these office procedures and involution of the uterus is greatly hastened.

Routine Procedure Prior to Gynecologic Operations

Prior to pelvic surgery the cervix should always be inspected. Curtis and others have called attention to fatal peritonitis, even after minor plastic operations, due to a liberation and spread of virulent streptococci from infected cervices. Serious infection following hysterectomy is not uncommon when the chronically infected cervix is disregarded. The present controversy between gynecologists as to the advisability of doing panhysterectomies routinely, takes into consideration the condition of the cervix. Although not proven, lacerated, scarred, infected, and eroded cervices seem to be fertile soil for carcinomatous changes. While it is true that nulliparous women do develop carcinoma of the cervix, chronic irritation and infection probably play a part in these cases. Many gynecologists feel that by amputation of the cervix, by the Sturmdorf reconstruction operation, or by coning out the endocervical tissues, they can prevent carcinomatous changes in the cervical stump

and do a supravaginal hysterectomy with less surgical risk. It is well established that panhysterectomy is not the operation for carcinoma of the cervix.

When Schiller announced his method of painting the cervix with iodine as a routine method for detecting early carcinoma of the cervix, physicians felt that they had a valuable aid in diagnosis. The method is useful, but only as an indicator of the areas to be excised for microscopic examination. The method is simple, and is based on the fact that when Lugol's solution is painted on normal cervical epithelium the glycogen of the cells is stained a mahogany brown color, and carcinoma cells, failing to stain, appear as pearly white areas. Eroded areas show a lighter brown color. The technic of this examination is as follows:

A bivalve speculum is gently inserted into the vagina. About 10 to 15 cubic centimeters of Lugol's solution is poured in and spread over the cervix with a tampon. After a minute, the solution is removed by a tampon or wiped out gently with cotton. The unstained areas are the suspicious ones and from these should be taken the tissue for diagnosis. This tissue may prove to be early carcinoma, hyperkeratosis from prolapse, or hyperkeratosis following leutic infection or damage to the cervical epithelium by tenacula or rough insertion of the speculum; the latter traumatic desquamations appear as narrow, sharp, and straight line scratches. This method of course is ineffective when the carcinoma begins in the cervical canal.

The earliest stage of cancer of the cervix is rarely seen. It consists of a hard nodule under an intact epithelium. These nodules can be felt before they can be seen and in these cases the Schiller method of staining is extremely useful. Most patients with carcinoma have had symptoms for three to six months before presenting themselves to the physician for examination.

As chronic endocervicitis, laceration of the cervix, cervical scars, eversion, ectropion and erosion are commonly found present with or preceding cancer, these conditions should be eradicated during the cancerous ages. To accomplish this, amputation of the cervix would seem the ideal method, but this operation should never be performed during the childbearing period without sterilization of the patient. Fatal hemorrhage during labor is the *great danger;* and cesarean section at term is a *far safer* procedure.

The Sturmdorf plastic operation on the cervix is a very useful method of cleaning up a severe endocervicitis. This operation is not simple, but when done correctly it removes the endocervical tissues and the scarred, thickened, hypertrophied cervical tissues. In addition, it relines the cervical canal with healthy squamous epithelium from the vaginal portion of the cervix.

A simple method of treating endocervicitis is to cone out the cervical and endocervical tissue. This can be done cleanly and easily by a high frequency coning knife. The older machines for this purpose were very expensive, but inexpensive apparatus is now available. The simplicity of this method has led some physicians to do this operation as an office procedure. This, I believe, is unwise. The patient should rest at least three days in the hospital and about one week more in her home. The immediate dangers from this operation are two-fold: lighting up of a virulent infection that has been latent in the cervical tissues; secondary hemorrhage from cervical vessels that were coagulated at the time of operation. This danger of hemorrhage can be greatly lessened by ligating active bleeding vessels and coagulating small bleeding points after coning the cervix. In spite of these precautions secondary hemorrhages requiring immediate packing or suturing do occur. Beginning ten days after the operation, warm douches of boric acid or normal saline will make the patient more comfortable by clearing up the leukorrheal discharge from the denuded area. About four to six weeks after the operation the squamous epithelium from below and the columnar epithelium from above cover the cervical canal and heal the operative site. Occasionally, contraction and healing will completely close the external os and it becomes necessary to dilate the canal. This complication is found more often after extensive removal of tissue in hypertrophied and deeply lacerated cervices. It seems unnecessary to say that all tissue removed from the cervix by biopsy or operative methods should be saved and sent to the pathologist. Only by this means will

early carcinoma be diagnosed and our percentage of cures be increased.

Summary

Inspection of the cervix should be made a part of every pelvic examination. Six to eight weeks after confinement the cervix should be examined and the needed office treatment given. Prior to a decision concerning gynecological operation, whether by the abdominal or the vaginal route, a careful inspection of the cervix will aid greatly in arriving at a wise decision and do much to conserve the health and life of the patient. If patients with carcinoma of the cervix are to be cured, every physician must be on the alert to detect changes in the cervix and to know by pathological examination the true condition of the tissues of this organ.

STRABISMUS*

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Strabismus is one of the most common eye conditions seen by the physician in the general practice of medicine, yet it is often one of the least understood as to its etiology and treatment. Our understanding of its development and treatment has changed so markedly during the past ten years that there is still too much diversity of opinion even among eye specialists to inspire confidence and coöperation in the prescribed methods for correcting the deformity.

The popular conception among laymen of the causes of strabismus are commonly accepted by the physician in order to avoid argument and the necessary time required to inform the mother that it was not the whooping cough that caused the child's eye to turn but rather other inherent deficiencies in the development of her child. It is very convenient to attribute our children's physical or mental handicaps to some unavoidable injury or sickness rather than to some abnormal germ plasm in ourselves. However, no single theory will today explain all types of strabismus and it is quite likely that there are usually several factors combining in any given case to result in the deformity. Briefly, the following factors are considered to be productive of strabismus: (a) Hereditary influences. These are commonly overlooked by the physician and laymen alike even though other members of the same family are similarly affected. (b) Defective fusion. At birth the child's eyes are not perfectly coördinated in their movements and such coördination does not take place for six to eight weeks. This faculty of working together is termed fusion and permits the individual to superimpose the images seen by the two eyes into one composit picture, which in its higher degrees of development gives us the depth perception enjoyed by most of us. This fusion sense may be congenitally absent, in which case it cannot be developed by any therapeutic measure. It is impossible to select those with congenitally absent fusion from those with poorly developed fusion until treatment has been tried. Those children having strabismus from birth or soon after birth usually have a congenital absence of the fusion sense. The majority of squinters have a poor development of the fusion sense at birth and show little tendency without appropriate treatment, to improve this function during the first six years of life as normal children do. (c) Refractive Errors. The lack of development of the fusion center in itself would not be likely to produce strabismus but when combined with refractive errors of high degree, strabismus is a likely result. In most instances of strabismus the vision is better in one eye than the other due to a higher degree of farsightedness or astigmatism. The child soon learns to ignore or suppress the blurred image and to fix with the better eye. (d) Abnormal Extra-ocular Muscle Balance. If there is a faulty fusion together with an abnormal extra-ocular muscle balance, the weaker eye will tend to deviate.

*From the Department of Ophthalmology, University of Michigan, Ann Arbor, Mich. Read before the General Session of the Michigan State Medical Society, September 30, 1937.

As a result of the deviation of the poor eye and its non-use, the central vision of the deviating eye becomes less and less acute so that amblyopia is produced.

There is a second form of strabismus, not due to the above causes but due to congenital or acquired paresis or paralysis of one or more extra-ocular muscles. Such cases are more easily understood and their therapy is entirely surgical in nature. Quite commonly, however, a paresis of one or more of the vertically acting muscles accompanies a non-paralytic horizontal squint. In such cases the paralytic portion of the deformity should be corrected surgically early in life so that the treatment of the non-paralytic horizontal squint may progress. Complete cures are less easily obtained in this group because of our inability to entirely overcome in all fields of fixation the variable displacement of the visual axes caused by the paralytic muscle.

As a result of the presence of strabismus in a child, there are certain important factors to be considered and prevented if possible. First, the cosmetic defect itself is a handicap in later life where personal appearance plays such an important part in one's success. Second, to be considered is the possible loss of useful vision in the squinting eye, thus making the child a one eyed individual throughout life thereby barring him from many occupations where binocular vision or useful vision in each eye is required. The fact that only one useful eye remains increases the hazards of ordinary life should the fixing eye become injured. The third consideration is that of the psychological influence which the crossed eye might have on the personality of the child. Permanent personality changes are very commonly seen and unless the condition is corrected before school age, the child is likely to become sensitive, shy, introspective and retiring in nature. The early recognition on the part of the physician regularly attending the child will in a large measure prevent this sequence of harmful events from occurring.

By a proper understanding of strabismus and its effects on the child, the interested family physician will direct the child into the hands of one specially trained in eye disorders, since the technical steps necessary for a complete cure are best carried out by him. Unfortunately we still find doctors advising parents of strabismic children that nothing need be done, that the child should be given a chance to outgrow their defect. That this advice is ninety-nine per cent incorrect is borne out by clinical experience. With a proper insight into the treatment of strabismus, the following steps should be carried out from the time the squint is first discovered.

At the first appearance of the strabismus, an ophthalmologist should be consulted since delay may cause valuable time to be lost and thus prevent the most rapid and complete cure. The longer the squinting habit persists, the more difficult it is to re-establish normal use of the eyes together. The first consideration of the ophthalmologist is the testing of the eyes under atropine to determine if there is need of correction in one or both eyes such as will influence the squint. Depending on the age of the child, from three to six months of constantly wearing needed glasses will indicate whether or not glasses will improve the squint by improving the vision and lessening overaccommodation. Along with the wearing of proper glasses, or if the child is seen earlier than one year of age before glasses can be prescribed, one per cent atropine should be instilled in the fixing eye once daily, or if atropinization of the fixing eye does not cause the child to shift fixation to the squinting eye, the fixing eye should be completely and constantly occluded by a patch in an attempt to improve the vision in the squinting eye. This is a very important step in that amblyopia develops in the deviating eye in a very few months. Our best results are obtained early in life and seldom are results obtained after six years of age. Atropinization or occlusion is not necessary in those possessing an alternating strabismus in that in these individuals the vision is always good in both eyes and amblyopia is not feared. Unless this prevention of lowered vision in the squinting eye is accomplished, a complete cure resulting in straight eyes having binocular vision and depth perception cannot be attained. By starting our treatment before six years and preferably before three years of age we now know that a good percentage of our amblyopic eyes can be trained to useful vision thus aiding us in later obtaining complete cures of the squint when the eyes are made parallel.

The fourth step in the complete cure of the strabismic child is the awaking of the

fusion sense or the ability to use the two eyes together after they have become straight. This treatment is carried out either before or after the eyes have been operated upon depending upon whether operation was necessary to make the eyes parallel. In the lower grades of squint, operations may be avoided if a high degree of fusion can be developed thus holding the eyes parallel. Fortunately fusion is sometimes easily developed and perfect cures are then possible providing all treatment is given before the end of the sixth year. Unfortunately, however, by far the majority of our squinting patients have been given glasses only and have not been in the hands of those interested in conducting the whole sequence of treatment through to a cure until after their seventh year of life when hope for a cure is lost. This problem of developing fusion so that the two eyes are restored to their normal functions is known as orthoptic training. On the whole this is a difficult form of treatment in that it usually requires the services of a specially trained technician who has plenty of patience and resourcefullness to hold the child's interest in these exercises over several months time. It is often difficult to obtain the parents' coöperation for this training in that they are not able to observe the improvement obtained and unless the squint is showing improvement they soon lose interest. Where the training can be carried out intensely in selected children under seven years of age brilliant results are often obtained. Unfortunately, orthoptic training lends itself admirably to the purposes of unscrupulous physicians and pseudo-medical specialists so that its proper place in the treatment of strabismus is clouded by many unfavorable impressions. When properly and intelligently used, orthoptic training is an important part of the treatment of strabismus. The average ophthalmologist is not equipped to carry out this form of treatment so that only a relatively few individuals have access to it. I am firmly of the opinion, however, that if the other forms of treatment are used when indicated as outline, that our treatment of strabismus would show results far superior to that ever obtained before.

Those children showing a squint of around fifteen degrees are often cured by the non-surgical methods. Those of greater degree usually require operative procedures on the eye muscles due to the presence of varying degrees of extra-ocular muscle imbalance. The correction of the muscle imbalance, thereby bringing the eyes into parallelism, facilitates the development of the fusion faculty. Once fusion is well established, the eyes will remain straight.

Most of us were taught in medical school that no surgery for strabismus should be attempted until the child was over twelve years of age. We now know that this teaching was inadequate and that there is more to the treatment of strabismus than the prescribing of glasses and later in life operating for residual crossing. Too many of these individuals had personality changes, a loss of useful vision in one eye throughout life, or an inability to attain binocular vision. By the former method of treatment, most children received the maximum correction of their squint within the first six months after wearing their glasses. Seldom was any attempt made to prevent amblyopia from developing. The parents were usually instructed that there was nothing further to be done aside from yearly refractions until after the age of twelve, when surgical straightening might be indicated. It was during this period of waiting for some miracle to happen to cause the eyes to become straight by inadequate non-surgical means that the greatest permanent damage was done.

By operating as early in life as it is found that the maximum correction has been obtained by the wearing of glasses, much improvement in our results is noted. We have found that less surgery is required to correct a given amount of crossing. By getting the eyes parallel before the age of six, fusion can often be developed, thus guaranteeing that the eyes will remain straight. There is little or no tendency for personality changes when the eyes are parallel before school age. Amblyopia prevention is carried on throughout the period of observation where improvement is obtained by occlusion of the fixing eye.

It is my feeling that operations should be undertaken as soon after the third year of life as possible and followed by systematic training to prevent amblyopia and to stimulate the development of fusion where practicable. Since the majority of our squinting cases do not present themselves

until after seven years of age, our corrections of necessity are usually surgical in nature and result only in a cosmetic correction of the deformity. The oculist will not be able to do the greatest service for his squinting patients until the public at large has been trained to present children for treatment at the first appearance of the strabismus.

In conclusion, we must admit that:

1. Our inability to prevent the development of strabismus is due to the multiplicity of factors which may combine to produce it.

2. There is no proof that illness and injury produce strabismus but that they are incidental to its occurrence.

3. A child developing strabismus should receive intensive treatment from its incipiency and the technical steps in this treatment are best carried out by the ophthalmologist.

4. The surgical correction of squint as carried out by present day methods is a safe and rational procedure and is only one phase of the treatment needed.

5. Only one per cent of squinting children develop straight eyes without treatment.

6. A child whose eyes are not straight by seven years of age is a neglected child.

AN ANALYSIS OF THE CONTRIBUTION MADE BY PNEUMENCEPHALOGRAPHY TO NEUROLOGICAL DIAGNOSIS

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This critical study of the data obtained by pneumencephalography as carried out at the Neurological Institute of New York was prompted by the request of the American Neurological Association to estimate the contribution made to neurological diagnosis by the use of air in the investigation of neurologic conditions. The results are formulated in response to several specific questions: (1) what was the proportion of cases suffering from organic neurologic conditions subjected to pneumencephalography; (2) in what conditions other than brain tumor were air studies employed; (3) in how many cases was the clinical study corroborated by air studies; (4) in how many cases was the clinical diagnosis proved incorrect by air studies; and (5) in how many cases was an incorrect contribution made to the diagnosis by the air studies.

To obtain this information the records of 500 consecutive patients suffering from organic neurologic disorders admitted up to April, 1936, were investigated. Patients suffering from psychoses, psychoneuroses, behaviour disorders and organic non-neurologic conditions were excluded from this series of cases.

It was found that 127, representing 25.4 per cent, of these 500 cases had either an encephalography or a ventriculography during their stay in the Institute. The number of patients investigated by encephalography was 116, representing 23.2 per cent of the entire group of 500 organic cases admitted consecutively to the hospital. Seven patients, or 1.4 per cent, of the entire group, were studied by means of ventriculography. Both encephalography and ventriculography were performed in four patients, or 0.8 per cent of the whole series.

The group of 127 patients investigated by pneumencephalography includes twenty-three definitely found to be suffering from intracranial neoplasms. The remaining group of 104 patients includes twenty-one cases in which no absolutely final diagnosis has been reached up to the present time. Certain of these patients are neoplasm suspects and it is quite possible that a number of these patients may subsequently develop expanding lesions. A considerable number represent situations which were considered suggestive of the presence of intracranial neoplasm and pneumencephalography was carried out in order to exclude as fully as possible this suspicion. Following the practical exclusion of this possibility the final diagnosis was made. The diagnostic distribution of patients investigated by pneumencephalography is as shown in Table I.

TABLE I (A). DISTRIBUTION OF CASES INVESTIGATED BY ENCEPHALOGRAPHY

No. of Cases	Final Diagnosis
29	Idiopathic Convulsive State
18	Post-traumatic Encephalopathy
16	Brain Tumor
6	Birth Injury to Brain
3	Post-infectional Encephalopathy
3	Porencephaly
2	Idiopathic Focal Motor Cortical Seizures
2	Chronic Encephalopathy of Unknown Etiology
2	Cerebrospinal Syphilis
2	Cicatrix in Brain
2	Hypoplasia: (One of cerebrum; one of cerebellum)
2	Multiple Sclerosis
1	Agnesis of Corpus Callosum
1	Retrobulbar Neuritis
1	Idiopathic Ophthalmoplegic Migraine
1	Rupture of Congenital Intracranial Aneurysm
1	Hereditary Sclerosis
1	Venous Angioma
1	Aneurysmal Varix
1	Chronic Adhesive Arachnoiditis
1	Polycythemia Vera with Disseminated Choroiditis
1	Huntington's Chorea
19	Diagnosis Deferred (Organic Neurologic)
116	Total

TABLE I (B). DISTRIBUTION OF CASES INVESTIGATED BY VENTRICULOGRAPHY

No. of Cases	Final Diagnosis
1	Left Parieto-Occipital Glioma; operated, verified
1	Bilateral Frontal Glioblastoma multiforme; verified at autopsy
1	Left Frontal Glioblastoma multiforme; operated; verified
1	Cerebellar Medulloblastoma; operated, verified
1	Brain Tumor Suspect; unoperated, unverified
2	Diagnosis Deferred (Organic Neurologic)
7	Total

TABLE I (C). DISTRIBUTION OF CASES INVESTIGATED BY VENTRICULOGRAPHY AND ENCEPHALOGRAPHY

1	Serous Meningitis
1	Agenesis of Corpus Callosum
1	Brain Tumor Suspect; Right Frontal; unoperated; unverified
1	Brain Tumor Suspect; operated; unverified
4	Total

In considering the question of correctness of the clinical study prior to pneumencephalography, it was found that in eighty-four cases, or 66.1 per cent of the group of 127 patients, the preliminary diagnosis was the same as the final diagnosis (Table II). In the 127 cases the clinical diagnosis was specifically corroborated by air studies in 70 cases, or 55 per cent, while in 14 cases pneumencephalography did not contribute in one way or the other.

TABLE II. CASES WHERE THE PRELIMINARY AND FINAL DIAGNOSES WERE IDENTICAL

No. of Cases	Final Diagnosis
26	Idiopathic Convulsive State
17	Brain Tumor Suspects
14	Post-traumatic Encephalopathy
6	Birth Injury to Brain
3	Post-infectional Encephalopathy
2	Multiple Sclerosis
2	Cerebro-spinal Syphilis
1	Huntington's Chorea
1	Polycythemia Vera with Disseminated Choroiditis
1	Hereditary Sclerosis
1	Brain Tumor Suspect or Multiple Sclerosis
1	Rupture of Left Middle Cerebral Congenital Aneurysm
1	Pituitary Adenoma
1	Idiopathic Ophthalmoplegic Migraine
7	Diagnosis Deferred (Organic Neurologic)
84	Total

In this group of 127 cases there were found twenty-nine, or 22.8 per cent, in which the clinical diagnosis seemed to have been proven incorrect by air studies, and these records were therefore scrutinized in greater detail. In seventeen of these twenty-nine cases the preliminary diagnosis had included the possibility, a bare possibility in many cases, that a neoplasm might be present and that its possible presence should be ruled out. In many instances this diagnosis was included merely as a suspicion, but not as a real diagnostic possibility. These seventeen air studies were reported to be normal or showed some degree of cerebral atrophy. In four cases, additional information was obtained by the air studies, but in these cases the data was informative and of interest only since it was not related in any way to the clinical diagnosis. In two cases the data obtained both clinically and by encephalography was insufficient to determine the correctness or incorrectness of the air studies.

In the remaining six cases the clinical diagnosis was found definitely to be incorrect. In one instance (No. 26794) the flat plates of the skull were first reported to indicate the presence of a meningioma and a clinical diagnosis of a meningioma was made. An encephalogram was performed and reported to be normal, thus disproving

the clinical diagnosis of a meningioma. The flat plates were therefore reviewed and the original roentgenologic error in the interpretation of the flat plates which misinformed the clinician was discovered. In the second case (No. 25618) a clinical diagnosis of idiopathic convulsive state was made, but the encephalogram showed a cicatrix of the brain. The clinical diagnosis in the third case (No. 27117) was "hydrocephalus" but the encephalogram showed no enlargement or distortion of the ventricular system. The fourth case (No. 26728) was that of an eighteen-year-old boy who presented a four-year history of tonic spasms of the right side of the body. These were always preceded by an aura consisting of a tightening of the muscles of the right arm and leg. Following this the patient would feel the toes of the right foot straighten out, the foot evert and the heel rise from the floor. There would also be slight flexion of the right arm at the elbow. These attacks lasted about ten seconds, during which he did not lose consciousness but was unable to speak. The neurological examination was negative except for bilateral nystagmoid jerks. Mentally the patient appeared to be normal. A diagnosis of neoplasm in the midbrain was made, but the encephalogram revealed normal ventricular and cisternal systems. While a definite final diagnosis cannot be made at the present writing, it was felt in retrospect that there originally was insufficient clinical evidence to justify the diagnosis of a mesencephalic neoplasm, and that encephalography had corrected an unwarranted clinical diagnosis.

The fifth case (No. 27144) was that of a twenty-three year old day laborer with a complaint of convulsions initiated by clonic movements on the right side. The first attack occurred when he was thirteen years old. When he was twenty years of age, left occipital headache made its appearance. He complained of tinnitus for the last year and dysthesiæ of the right upper and lower extremities for the past six months. The right abdominal reflexes were diminished. This was the only positive evidence obtained by neurological examination. A clinical diagnosis of a left infiltrating parasagittal neoplasm of the brain was made, but the encephalogram was normal. The final diagnosis was that of idiopathic focal motor cortical seizures. It may be pertinent in this case also to question the justifiability of such a clinical diagnosis upon such limited evidence.

The sixth patient (No. 27033) was a forty-three-year old housewife with a history of mental changes following pregnancy which occurred two and one-half years before her admission. She later developed a tremor of the right hand, a tendency to trip and fall, blurring of vision, tinnitus, headaches, vomiting and a left hemiparesis. On examination she presented a left hemiparesis with hyperactive deep reflexes, diminished abdominal reflexes and a positive Babinski sign on the left side. Examination of the fundi revealed a marked papilledema with hemorrhages and exudate. There was a suggestive right mimetic facial weakness but it was so questionable that one examiner even placed it on the opposite side. The patient was euphoric and disoriented. A clinical diagnosis of a right frontal neoplasm was made. A ventriculography was performed and the films unequivocably reversed the localization and revealed the evidence of the presence of a left parieto-occipital neoplasm. The patient was operated upon and the presence of a left parieto-occipital glioma was verified. It is interesting to note that five examiners confirmed the clinical localization of this neoplasm on the right side, all of them being deceived by false localizing evidence. The clinical picture was so convincing that no conflicting diagnoses were made.

In determining the number of times that an incorrect contribution had been made to the diagnosis by air study, it was found that this occurred in one instance, representing 0.7 per cent of the 127 cases. However, in reviewing this case thoroughly and in retrospect, it was found that the error was the result of an incorrect interpretation of the actual significance of the air shadows as seen in the ventriculogram rather than being due to misleading information provided by the air study per se. This was a case (No. 25761) of a sixteen-months-old boy who had been born by version and extraction and was well till the age of fifteen months, when he developed a left internal strabismus. This was followed by irritability, drowsiness and vomiting. He lost his appetite, voided frequently and was no longer able to sit up. It was thought that his head had grown larger. Examination show-

ed a drowsy child with a large head and a positive MacEwen sign. He had bilateral papilledema, slight internal strabismus and horizontal nystagmus. The left pupil was larger than the right. There was spasticity of the left arm while the left knee-jerk was increased as compared with that of the right side. Bilateral ankle clonus and Babinski signs were present. Flat plates of the skull showed evidence of increased intracranial pressure. A clinical diagnosis of medulloblastoma of the cerebellum was made. The ventriculogram was then reported as follows: "Marked hydrocephalus. The complete lack of air in the third ventricle except for the vicinity of the foramen of Monro makes it seem likely that there is a lesion occupying most of the third ventricle." The patient died and an autopsy reported: (1) "Medulloblastoma of the cerebellum extending into the subarachnoid space"; (2) "Internal hydrocephalus—secondary." The roentgenograms of this case were reviewed in connection with this study and in retrospect, as stated above, the error in localization was found to be due to an incorrect interpretation of the air shadows, inasmuch as subsequent study showed that the outline of a dilated third ventricle could be seen. The failure to recognize this dilated third ventricle caused the reviewer to predicate a third ventricle lesion rather than a subtentorial neoplasm causing a uniform dilatation of the entire supratentorial ventricular system, thus contributing to a serious diagnostic error.

In the remaining thirteen cases of the 127 which were investigated by air studies, the information provided by this means of examination was either not relative to the final diagnosis or the evidence was insufficient to provide a definite diagnosis.

Summary

It is found that air studies were done in 25.4 per cent of all organic neurologic cases in this hospital, using 500 consecutive admissions as a cross-section.

Of the 127 air injections reviewed in this study, twenty-three, or 18.1 per cent, were performed on patients found to have brain tumor, while 104, or 81.9 per cent, were performed on patients apparently suffering from some other organic neurologic disease.

In seventy cases, representing 55 per cent of the 127 patients investigated by pneumencephalography, the clinical study was corroborated by air studies.

In six cases, representing 4.7 per cent of the 127 air injections, the clinical diagnosis was proved incorrect by the air studies.

In one case, representing 0.7 per cent of the 127 air injections, an incorrect contribution to the diagnosis was made by the air studies.

PROBLEMS IN VENEREAL DISEASE CONTROL*

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The term, venereal disease control, is being used in this title rather than syphilis control because emphasis should be placed in the current campaign on the control of gonorrhea, as well as syphilis. Little emphasis has been placed on gonorrhea because we lacked an effective means of rapidly controlling infectiousness. Our experiences with sulfanilamide at the Social Hygiene Clinic in Detroit would lead us to believe that in it we have a drug for the treatment of gonorrhea that will closely parallel the effectiveness of salvarsan in syphilis. We realize that we may be too optimistic and that possible late toxic effects may dampen our enthusiasm. But, with such a weapon in our hands, gonorrhea need no longer be considered such a hopeless problem from a preventive medicine standpoint.

Your Advisory Committee on Syphilis Control of the Michigan State Medical Society has outlined a plan of attack combining the services of our health departments and medical profession. You are probably acquainted with this plan. The high points are: the request that the family physician be given an opportunity to carry out the treatment with some compensation for in-

*Read before the seventy-second annual meeting of the Michigan State Medical Society in Grand Rapids, September, 1937.

digent patients; that the State Health Department supply the drugs, laboratory facilities, active follow-up of sources, contacts and lapsed treatment cases; and finally full-time consultants in needed areas. The only thing needed, and unfortunately, it is the all-important one, is the necessary funds to put this plan into execution.

The public has shown an interest and avidity for information that is surprising. The spirit of taboo surrounding venereal disease has been broken down. Syphilis is news. Any thinking person must admit that venereal diseases are an outstanding public health problem. The supposed spirit of taboo has been used as an excuse for neglecting this important phase of public health work. Even, with the stage set, little has been done to crystallize public opinion into an overwhelming demand upon our legislators that something be done about it. It cannot be cost, since the public gladly supports our laudable tuberculosis campaign. Yet, it costs probably twenty-five times as much to treat a case of tuberculosis as one of venereal disease. Furthermore, aside from our desire to prevent needless suffering, it can be shown readily that the cost of an effective campaign for venereal disease control will be returned many times in reduction of loss of time through invalidism and taxes for institutional care. If the present control program fails, the fault can only fall on the shoulders of our profession and our boards of health, through lack of interest and failure to capitalize on this opportunity.

Our State Legislature has appropriated $50,000 for syphilis control, as a result of the publicity already given this program. $25,000 of this amount is to be used for laboratory and other expenses incident to the prenuptial physical examination law. $5,000 has been returned to the State Treasury, as a result of the Governor's request for general budget reductions. This leaves $20,000, which the State Health Department plans to use toward supplying free anti-syphilitic drugs for indigent patients. This money is so recently available that detailed plans have not been formulated as to how it will be spent. Unfortunately, no national funds are seemingly available for venereal disease control, at least, in Michigan. The public generally believes that both national and state funds have been available and are surprised to learn that the program has had, up to the present, little more than moral support. This $45,000 will help. No one knows how far the $20,000 will go toward meeting the demand for drugs, when limited to supposedly indigent patients. It has been suggested that free drugs be withheld from clinics already treating indigent patients, that have a budget for this purpose, to make the supply spread farther. It is questionable whether such distinction can be made, at least without the consent of the organizations concerned. Undoubtedly, some physicians' statements of indigency will, at times, be quite elastic. This problem can only be solved by having sufficient funds to supply drugs, where requested, for all cases of syphilis under treatment. One hundred thousand dollars would be a minimum working budget, permitting more leeway in supplying drugs and at least, a skeleton Division of Venereal Disease Control, under our State Health Department. $250,000, to set up a complete division with consultants and trained investigators for follow-up work, would be desired. Spend $500,000 to $1,000,000, which would be necessary, if a completely effective plan including payment of physicians for care of indigent cases, for a period of 10 years, and we, in Michigan, would be able to match the reduction in Scandinavian countries. This is only a fraction of the money we spend yearly for tuberculosis control. We have 12 times as many cases of venereal disease as of tuberculosis. The total mortality and crippling effects are higher. With our available specific drugs, venereal diseases can be much more effectively controlled. The question reduces itself simply to this—Are we willing to spend the money? It is our duty to bring these facts forcefully to the public and the funds will be available.

I am not qualified to outline a program or speak of the problems incident to lay education. It would, however, seem to me that efforts along this line have lacked a unity of purpose and sequence in presentation. Publicity should be largely under the guidance of our State Department of Health with our medical societies and lay organizations coöperating. The plan recommended by Indiana sounds commendable. They propose a committee consisting of a member appointed by each local medical society

and all health officers to be known as the "State-wide Committee." They propose sub-committees to function in communities where they exist, consisting of representatives from hospitals, nursing associations, social service workers, community fund, better-business bureau and lay organizations of all types. The larger each committee becomes, the greater its sales ability. The sub-committee should carry out the plans advocated by the State-wide Committee.

We still have much work to do in preparing our physicians with first-hand outlines of the principles of modern treatment and selling them on the idea of following such outlines. If the campaign is to succeed, especially with our aim of placing active treatment in the hands of the family physician, teamwork must prevail. Public health workers are skeptical that such a plan can work. It is up to the physicians of Michigan to prove that they can fit effectively into a program of public health control. It will be necessary to give up our individualistic leanings and willingly follow, in the interests of unity, at least, the principles of a prescribed system of diagnosis and treatment. Any successful campaign must have such a basic unity of aims and guidance. Personally, I fear this stumbling block much more than the often expressed one of inadequacy of the average physician. Not all physicians are interested in the treatment of venereal diseases. Those that accept such cases for treatment either are, or should be, fairly proficient or anxious to avail themselves of such condensed information, as we can supply. Our state and county medical societies, the postgraduate courses of the University of Michigan, the Joint Committee on Health Education, the Michigan State Health Department, et cetera, have and will continue to make such information available.

One pressing problem for which I have heard no solution, with the possible exception of the medical coördinator plan of personal contact used in Detroit, is how to reach the "back-slider" in our ranks. Such a physician does not belong to his medical society, does not attend medical meetings, read our journals or avail himself of postgraduate instruction. He is a rank outsider in a campaign such as this. We are trying to prepare a list of coöperating physicians in Detroit, who are interested in one or more phases of venereal disease control, are willing to adjust charges according to the patient's ability to pay, avail themselves of literature and graduate instruction and coöperate in this program. They will form our army in its drive on venereal disease. It is the back-slider, plus a few rare crooks and incompetents, who bring discredit on our medical profession in a campaign such as this. I wonder how soon organized medicine, for its own protection, will develop enough gumption to begin a house cleaning.

One of the problems, which has been brought to light in this campaign, is the lack of insight by the laity, as to the communicability of venereal diseases. We have industrial plants in Detroit, that not only refuse to hire, but discharge any employee suffering from either gonorrhea or syphilis, regardless of its stage. A blanket order has been passed, refusing to re-hire men having syphilis, as long as their Wassermann test is positive. It is very desirable from a public health standpoint to have routine serologic tests in industry but, at least, non-infectious cases found thereby, should not be discharged. Our welfare rolls will be swelled to an unwarranted degree, known cases will be forced into hiding, and discovered cases will be handicapped in securing treatment. Compensation for industrial disease has augmented the problem. This is an urgent matter that warrants some recommendation by the United States Public Health Service and the Department of Labor.

It should be clearly emphasized, as a part of our lay education, that gonorrhea is transmitted only, with very rare exceptions, by sexual intercourse. The main exception, gonorrheal vaginitis, is not a problem of industrial contact. It should be emphasized that the possibility of adults contracting gonorrhea through toilets and in industry, are extremely remote. Likewise, that syphilis is contagious only in its early stages, or roughly during the first five years; that once recognized and treatment begun and continued regularly, infectiousness should be controlled within 48 hours; that later stages of the disease are not infectious, even though open lesions are present; that cases of late syphilis need not be shunned; that the Wassermann test is not a guide to infectiousness; that with the exception of congenital infection, the disease is acquired, almost entirely by direct contact with moist lesions through intercourse

or kissing; that a patient is immune to a new infection of syphilis, as long, but only as long as, he has the disease; that congenital syphilis is acquired from the mother, not direct from the father; that congenitally syphilitic mothers rarely have congenitally syphilitic children, and finally, that congenital syphilis can be prevented if every mother having acquired syphilis, or a history of same, be treated during every pregnancy.

The communicability of syphilis brings up another problem in its public health control. It is only the early case, and syphilis in pregnancy that are primarily public health problems. The late case is an individual problem as with any chronic disabling disease. Therefore, where limitation of funds is necessary, as it probably will be for some time in Michigan, it would be advisable to limit public health activities largely to this group of infectious cases, leaving the management of the frank late case to the patient and his physician.

If our campaign of venereal disease control is to succeed, more trained follow-up workers will be urgently needed. Their efforts should be spent in running down sources, contacts, and lapsed treatment cases, that are potentially infectious. It is doubtful if they will ever be available in sufficient numbers, or it be desirable to use them in coercing late non-infectious cases to continue more than 18 months of active treatment. These late possibly Wassermann-fast cases are a physician-patient problem, and not a public health one. Yet, it is precisely this type of case for which we get many requests for follow-up, because of lapsed treatments. Physicians should not expect to use their health departments or the influence of this national campaign, as a threat to keep such cases under treatment indefinitely. The Detroit Department of Health will coöperate gladly to the limits of its personnel, in fact, urgently desires to aid physicians in contacting all possible sources, contacts, potentially infectious lapsed treatment cases, and pre-natal syphilitic cases. Full powers of enforced quarantine will be utilized where indicated. It is hoped, for Detroit, at least, when funds permit additional personnel, that assistance can be given physicians in urging their late non-infectious cases to continue treatment until a minimum modern standard of total treatment is administered. We cannot force treatment on such cases.

Our recent prenuptial physical examination law requiring certification of freedom from venereal disease with mandatory Wassermann or Kahn test for both parties becomes effective October 29, 1937. Correspondence with the health departments of the six states having similar laws, makes one less fearful of probable medical problems than on first thought. A possibility of contract medical examinations on a split fee basis exists, but laws penalizing such practice can be enforced, if needed. It is felt that the blanks for certification should be distributed direct to the physicians, county medical societies, or health units, instead of as proposed, only through county clerks. The law clearly states that examinations must be made by licensed physicians, which should curb any tendency to demand free examinations in clinics. If people can afford to marry, they should be able to pay, at least, a moderate fee for examination. No attempt has been made to set up fee schedules and should not be necessary in Michigan. It is to be regretted that a companion bill before our State Legislature requiring a mandatory Wassermann test during pregnancy was defeated.

The prophylaxis of venereal disease is an important phase of our present campaign. Many believe that it is too delicate a problem to emphasize at the present time for fear of antagonizing certain groups. The idea is frequently expressed that the knowledge of and the use of prophylaxis undermines moral restraint and fear of infection, and thus increases exposure. Instead, it is firmly believed on a basis of many years' observation in world-wide military organizations that use of enforced prophylaxis keeps the possibility of infection constantly in mind and reduces the frequency of sexual exposure. Certainly, reliance on moral persuasion has failed throughout the centuries. Moral, religious or other influences should not be neglected, but every weapon of proven value in combatting venereal disease should be utilized. Other states have made definite progress. Supervision and regulation of mechanical and chemical prophylactics by our State Health Department, would be a logical step. Publicity through drug stores and public urinals would help. Finally, chemical prophylactic

stations, strategically located and open all night, should be established in our larger centers of population.

The desire for secrecy, plus avoidance of medical fees, as has been shown by several questionnaires, drives the majority of persons with venereal disease first to the counter-prescribing drug store. This fact is to be regretted and if these diseases are to be stamped out, such sense of shame and false economy must be corrected, or controlled. It not alone causes delay in diagnosis, increases complications and materially reduces the chance of cure, but greatly increases our crop of new cases. It should be the duty of our medical societies and health departments to contact and secure the coöperation of the Retail Druggist's Association in urging their membership, plus any pressure they might suggest on their non-member associates, not to treat venereal diseases, but to refer such cases to physicians at once.

Time does not permit discussion of many other problems of our current venereal disease program. Venereal diseases can be controlled, and at less expense than any of our major public health problems. The present program will succeed if we give it our enthusiastic support. The necessary funds can be secured, if the program is given such support by our physicians and health departments, plus organized widespread publicity. If the campaign fails, we can only blame ourselves.

THE EDUCATION OF THE PUBLIC IN CANCER

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The Michigan State Medical Society through its Cancer Committee has very definitely committed itself to a program of cancer education. Its success depends upon the interest and enthusiastic participation of every doctor in the state. As a result of the experience of the past three years, the necessity of a systematic attack has become apparent whereby, as far as possible, standardized statistical and factual material is disseminated to the public. To this end a large cancer sub-committee has been appointed, representing geographically the entire state upon whose shoulders will fall the bulk of the burden of talking to lay groups. Men have been selected to serve on this subcommittee because of the interest in the subject and their speaking ability. This by no means reduces the responsibility of every physician and minimizes in no way the importance of his assistance.

It is believed desirable to acquaint the public with the prevalence of cancer, a disease which ranks second as a leading cause of death and accounts for nearly 150,000 deaths in the United States annually. In the past thirty years, it has risen from tenth place to its present position and if its prevalence increases at its present rate for the next thirty years, it will kill over a quarter of a million people in this country annually. However, if proper methods are applied and present facilities and knowledge properly utilized, the death rate from cancer instead of increasing in the next thirty years should drop fifty per cent. It could be said to an average audience of one hundred women of thirty-five years of age each that thirteen of them will die of cancer at the present rate; at fifty years, one out of six. However, statistics have small constructive value and must not be used to unnecessarily frighten those whose fears we wish to allay.

The next logical step is to explain the nature of cancer, the biological differences between neoplastic tissue, between malignant and benign tumors and the phenomenon of metastasis. The important role of the various forms of chronic irritation in the development of cancer should be stressed and lead to the very important subject of cancer prevention. In this connection the removal of benign tumors, particularly of the breast and skin, can be stressed as an important step in cancer prevention. In dealing with heredity, it can be accurately stated that there is a definite hereditary influence in the development of cancer. When discussing cancer biologically, an ex-

cellent opportunity is afforded to explode many of the fallacies and misconceptions held by the public and to replace popular misinformation with true facts. The successful treatment of cancer, consisting as it does of the removal or destruction of the malignant lesions before metastasis occurs, makes the use of surgery, radium and x-ray therapy quite plausible and renders an opportunity to condemn quackery and unscientific methods in general. A generous number of illustrations of successfully treated patients cannot help but be impressive. As nearly as can be estimated, a quarter of million people have been cured of cancer in the United States of which Michigan's share would be about 6,000. The element of delay as a factor in cancer mortality cannot be over-emphasized. In treatable cancer, good results can be obtained in from seventy to a hundred per cent of early cases, and in only zero to thirty per cent in late stages. In other words, early cancer is curable.

Doubtless every doctor who is called upon to give a cancer talk will develop his subject along similar lines. The public, however, is skeptical and certain obstacles, not insurmountable, present themselves.

First, the public openly accuses the medical profession of not knowing the cause and cure of cancer. If it is to be assumed that there is but a single cause and a single cure of cancer, there is some truth to the accusation. Much is still to be learned about cancer. However, as much progress has doubtless been made, as much information added, in the past ten years in cancer as in any other major disease. Much of the present cancer information cannot be applied because of lack of coöperation on the part of the public. People are inconsistent in flaying the medical profession for its lack of accomplishment in cancer. There seems to be no criticism of the fact that the causes of hypertension and arteriosclerosis are unknown and that there is no curative treatment for such consequences as cardiovascular-renal disease, coronary thrombosis and apoplexy. We can control diabetes and pernicious anemia, but do not know their causes. Tuberculosis is still a serious disease and pneumonia threatens to push cancer out of second place as a mortality factor.

I am unable to view cancer as the great mystery of medicine. We know a great deal about the origin, development and progress of malignant lesions. A pre-cancerous lesion occasionally becomes malignant under observation. It is as easy to understand the mechanics of cancer as of many other diseases. To refer to a cancer "problem" is probably a fallacy because thereby is conveyed the impression that some day the problem will be completely and suddenly solved, as one would solve a puzzle or a problem in arithmetic. Future progress in cancer will doubtless be slow, constant and continuous, but not spectacular.

The next obstacle to be encountered is fear. There are two kinds of cancer fear. First there is the fear engendered by knowingly having the disease or suspecting its presence, which is understandable. But more important is the unreasoning, abstract fear, not of the disease, but of the subject. Many people have their ears, their eyes and their minds closed to information regarding cancer because they consider it a hideous, repulsive subject, one too revolting for their consideration. Much of this attitude is inherent and some is the result of unfortunate contacts or descriptions of ugly, neglected cases which might have been cured had they been attacked in an early stage. Perhaps some cancer talks in the past have been too gruesome. Intelligent people often feel that they must protect their finer sensibilities against such shocks. The public must be made to understand that cancer is not necessarily a foul, unsightly disease and that the subject is not necessarily unpleasant. Cancer talks must be made interesting and instructive, but not obnoxious. Until cancer can be talked about freely and openly, without discomfort or restraint, no real progress will be made in cancer control. Furthermore, no amount of medical knowledge will be applicable unless this barrier of unreasoning fear and reluctance to listen can be broken down.

The public is definitely skeptical about the curability of cancer and while we know that there will be a high cancer mortality for many tomorrows, good results are by no means rare. For the purposes of cancer education, more could doubtless be accomplished with less effort and in a shorter time by concentrating upon accessible cancer—that is, the skin, lips, mouth, breast and uterus. This is an important group. Cancer

of the breast and uterus constitute approximately half of female cancer. It is a group in which early diagnosis can be made and in which prompt treatment produces favorable results. It is necessary to stress good results in any cancer program in order to replace some of the existing, unjustified pessimism with warranted hopefulness.

In accessible cancer lies a fertile field of preventive medicine, especially cancer of the skin, mouth and uterus. Many of the forms of chronic irritation leading to the development of cancer of the mouth can be recognized, removed and corrected. Precancerous skin lesions can be eradicated. Postnatal damage to the cervix can be repaired. Cancer prevention is not a myth but it should be applied to the types of cancer which are associated with demonstrable carcinogenic influences. The best form of cancer prevention consists of frequent, periodic, complete physical examinations or health audits which would detect much cancer in a treatable stage.

Simple rules must be given the public for the early recognition of cancer. The danger of persistent lumps, bleeding, discharge and sores, must be emphasized. A warning regarding the frequent absence of pain must be sounded. The symptomatology of cancer is often varied and complex and it is undesirable to give the public a long list of signs and symptoms and expect cancer patients to make the diagnosis. It would be better to instruct them to turn to their physician when there is a definite deviation from normal good health and the proper advice will be obtained. A healthful inquisitiveness among people regarding their own bodies should be stimulated in order that obvious lesions can be recognized earlier. It is not infrequent for a woman to apparently suddenly discover a lump in her breast which had doubtless been present for some time.

The public must be informed of the nature and the danger of cancer and the conditions under which the disease can be controlled. Protection against cancer is something real and practical and consists of the application of well established cancer facts. Knowledge disseminated for this purpose must be of a public health rather than a medical nature. A receptive attitude toward cancer information must be created. The prevailing picture of cancer as a hopeless, horrible disease must be replaced by an intelligent constructive interest and a willingness to thoroughly coöperate with medical forces. Cancer must take its place as a clean disease. Cancer information to the public must be educational and free from objectionable features. It must be clearly understood that cancer under proper conditions is curable. Cancer can be controlled only by a prolonged and relentless attack, with common sense replacing hysteria.

REPORT OF OBSERVATIONS OF THE INSULIN HYPOGLYCEMIC SHOCK TREATMENT ON PSYCHOTIC PATIENTS*

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The information contained in this report was obtained while watching the insulin hypoglycemic shock therapy as it was carried out on approximately twenty patients over a period of three weeks as well as from conversations with various men associated with this work. Those included are Dr. John R. Ross, superintendent of the Harlem Valley State Hospital, and his associates, Dr. Nolan D. C. Lewis of the New York State Psychiatric Institute and Hospital, and Dr. Harris, who is supervising the treatments there; Drs. Bryan, Sleeper and Cameron of Worcester State Hospital; Dr. Adolph Meyer and Dr. Katzenelbogen of the Phipps Clinic of the Johns Hopkins Hospital, as well as personal interviews with Dr. Joseph Wortis, who is treating some patients in Bellevue Psychiatric Hospital, New York; and Dr. Manfred Sakel, who made weekly visits to the Harlem Valley State Hospital and who was also interviewed in New York. Information from so many sources of necessity requires treatment rather by summary than by an attempt to detail a variety of attitudes.

*Read before the Detroit Neurological Society, March 18, 1937.

It might be said that there are almost as many attitudes toward the procedure as there are individuals associated with it. Again, the picture is further complicated by the fact that the treatment in itself is a complicated and highly variable one which is further changed in detail by each one who is carrying it out, and even its originator, Dr. Sakel, is himself modifying it as time goes on. Therefore, we have the highly complex picture of the varying diversifications of a changing technic. As this is essentially a report of observations, no attempt will be made to completely review the literature.

In brief, the treatment as ordinarily described in the literature,[4,8,9,10,12,13,14] and even in Dr. Sakel's most recent* article,[11] is one in which the patient is given almost daily increasing doses of insulin until the desired hypoglycemic shock is produced. The dose which produces this shock is continued as the "shock dose" six days out of the week until the desired results are obtained; after which the patient is given less severe shocks sometimes by smaller doses of insulin in the phase known as the "polarization phase." Each treatment is terminated by giving some form of sugar at the indicated time. Usually during the shock treatment, it is necessary to give this sugar by stomach tube, and occasionally intravenously. The time of this termination of the shock is perhaps the most important and the least understood part of the procedure. The purpose of the procedure is to produce what personality changes are possible by insulin shock which Dr. Sakel, from his experience with insulin in treating morphine addicts, adduced would benefit the schizophrenic. Perhaps, briefly, it might be stated that insulin shock produces certain changes either neurological or psychic, or both, which result in some change in the personality which in fortunate cases relieves or destroys the psychosis.

The most recent modification advocated by Dr. Sakel and the one now used at the Harlem Valley State Hospital, where they perhaps most closely follow his advised routine, is one in which the final smaller or polarizing doses of insulin are omitted. Thus, let us say that in an average case the patient is given in the morning of the first day 20 units of insulin. The effect of this relatively small dose may be very slight and the patient recovers spontaneously, but none the less at the end of three or four hours he is given the interrupting dose of sugar by mouth. With each succeeding treatment, the dose of insulin is increased from five to ten units until the patient demonstrates during the period of hypoglycemia the desired effect. Thus the final or shock dose may vary between wide limits, but might possibly end up at between 50 and 100 units. This shock dose then is continued almost daily until it is thought the patient has derived a maximum benefit from the treatment. Usually, with these larger doses, termination of the shock must be effected through the stomach tube or intravenously. Dr. Sakel is apparently now also leaning toward a more frequent use of adrenalin, to interrupt the coma more quickly. If the patient shows very little or no improvement after from 60 to 70 of these shock dose treatments, he is considered as probably a poor result and discontinued from treatment or at least given a few weeks rest period before making another similar attempt. During the course of the treatment it may appear advisable to change the size of the shock dose, for either the patient may apparently build up a tolerance to the insulin given and not become as comatose as desired, or he may apparently not be able to withstand so severe a dose and show undesirable symptoms, whereupon the desired shock dose is found to be smaller. The final or polarization phase, in which less severe shock is produced in the termination of the treatment, is no longer advised by Sakel because he feels that giving anything less than the therapeutic shock may leave the patient in an undesirable state. He feels that the patient tends to be fixated at the psychic level present at the time of termination of each shock.

Before going further, it might be well to stop for a moment and consider some of the physiological changes which occur as the result of this insulin hypoglycemic shock. Obviously, the administration of insulin lowers the blood sugar, and, as the doses are increased, of course the blood sugar at a set time after its administration tends to reach lower levels. However, there are no really consistent findings as to the lower limits to which it may fall, and appar-

*At the time of writing, this was the most recent article by Sakel available. Others have appeared since.

ently very little relationship between the size of the dose of insulin given and the depth to which the blood sugar descends. From various sources it is apparent that the true fermentable blood glucose rarely goes below 18 or 20 milligrams per 100 c.c. of blood. The lowest reading obtained was 13 milligrams in one case. When to this is added the non-fermentable reducing substances, which are variable in amount, we may well have an ordinary blood sugar reading of 25-30. It seems peculiar that no lower readings than this were obtained. Certainly not the findings corresponding to those reported in rabbits,[3] in which, due to insulin shock with convulsions, the true fermentable glucose of the blood stream disappeared entirely. In humans the blood sugar has remained at its lowest ebb for one and one-half hours before a convulsion appeared. Lower blood sugar values have been found in humans with widespread liver disease, because apparently there is no glycogen reserve from which to produce circulating glucose in these individuals. Obviously, after the interruption of the hypoglycemia with the solution of sugar by stomach tube or glucose intravenously, the blood sugar values must reach very high levels, later returning to normal.

Intimately associated with glucose metabolism, of course, is that of phosphorus. It is well known that when insulin is given and produces hypoglycemia there is a coincident fall in the blood phosphorus. This is generally conceded as being the result of the formation of hexose phosphate as a step in the formation of glycogen out of glucose. However, it is reported[6] that there is a continued increase in phosphorus excretion in the urine even on the days without treatment, and the final explanation of this is not entirely clear. There is ordinarily found with changes in the blood sugar toward hyperglycemia a compensatory fall in the blood chloride presumably to maintain a constant osmotic pressure. However, when the blood sugar falls due to insulin, although there is a distinct increase in the blood chloride, this is not felt by Chaikelis,[2] in experimenting on rabbits, to be adequately explained merely on the theory of restoring osmotic pressure of the blood because the change in blood chloride greatly overcompensates for the change produced by the fall in blood sugar. Furthermore, this author also points out that the rise in blood sugar due to adrenalin injection is not accompanied by the expected fall in blood chloride. He proposes the idea that during insulin hypoglycemia there is stimulation for the pouring out of adrenalin into the blood stream which, it is known, influences metabolism in such a way that lactic acid is increased in amount. In order to maintain normal acid base equilibrium in the blood there would be, with the increased lactic acid, removal of a certain amount of bicarbonate. With this change of bicarbonate-chloride ratio in the blood, there would be a tendency for chlorine to shift from the tissue fluids into the blood stream to maintain the constancy of the acid base ratio. Furthermore, he feels the formation of hexose phosphate during the metabolic changes of the blood glucose might also contribute to the shifting of the chlorine from the tissues to the blood. This shift of chlorine to the blood would presumably leave excess of sodium in the tissue fluid. Water from the plasma would tend to shift to the tissues with this retained sodium, in order to maintain isotonicity of the intracellular and extracellular water. These entirely theoretical considerations are thought to be consistent with the changes in weight observed in some of the cases that will be referred to later.

It has been found by some that the injection of insulin causes a drop in the amino-acid content of the blood almost in molecular proportion to the drop in the glucose of the blood, and this phase of the metabolic changes is at present being studied, although too few observations have been made to warrant drawing any conclusions. A marked increase in the metabolic rate is reported by Gross[6] during the treatment with profound insulin shock. It will be noted that his calculations are based on Read's formula, concerning which there is increasing evidence that this is not a true index of the rate of oxygen consumption. However, at present no studies are apparently available concerning the oxygen consumption of these patients during the treatment. There is apparently no more than minimal changes in the blood calcium, inconstantly a rise. Although there is reported a moderate anhydremia of the blood during insulin shock, this is not sufficiently large to account for the supposed increases in the cellular content. Not only do the red cells increase, but there is also a disproportionate leukocytosis.

Changes of the cardiovascular system during the shock treatment are various. In most cases in which the cardiovascular system is not greatly affected, there is little change in the pulse rate even during rather profound shock. There may be rather quick changes in rate, varying possibly from 70 to 90 and back to 70 again within a short time, but this is not considered to be a serious matter. It is explained upon the changes in dominance of the two opposing autonomic controlling systems of the heart. However, there occasionally occurs a very marked tachycardia and when the patient's pulse is noticed to range from 90 to 100, to 110, to 120, etc., thus maintaining a progressive increase in rate, this is considered to be a matter of serious significance and the shock is interrupted. The same holds true for a very marked bradycardia, when the pulse falls to between 30 and 40, which again is an indication for termination of the shock. These variations in rate, when followed on the electrocardiogram, are found to be of nodal origin. There are also certain irregularities of the heart beat which are due to auricular or ventricular extra systoles. The electrocardiogram is supposed by some in studying the heart in insulin hypoglycemia to have a flattening of the "T" waves. This is supposedly due to some alteration in the metabolism of the heart muscle itself, but is far from a consistent finding, and, in fact, others just as often find increased amplitude of the "T" wave. However, there is found an increase in the Q-T interval. This reveals a perfectly normal Q.R.S. complex, but since the entire interval is prolonged, it suggests that there is a slowing of not only the period of contraction but also of the period of relaxation in the cardiac cycle. It is interesting that this E.K.G. change is also found in disturbances of metabolism associated with low blood calcium. Blood pressure as a rule shows no marked change, although there may be some increase in systolic and lowering of the diastolic pressure. Obviously, if there is a sudden drop in the blood pressure, a weak thready pulse, signs of cardiovascular collapse, the coma must be terminated.

The respiratory mechanism not infrequently shows distressing complications that must be watched. Apparently there are a few patients who go into a respiratory collapse in which the respirations become slower and shallower during the shock treatment. This is thought to be of sufficient significance to terminate the shock. Apparently severe bronchial spasm has been observed in which there is very marked expiratory obstruction, the lungs finally becoming ballooned up with air, and this may in itself go on to asphyxia if not interrupted. Spasm of the glottis is not infrequently found, evidenced by loud, rumbling respiration which is not relieved by changing the position of the patient's head in an attempt to shift the tongue, which may have fallen back and caused a similar picture. If this continues over a period of time and interferes with the respiratory efficiency, it is thought best treated by terminating the shock.

There are few gastrointestinal symptoms to be noted except that occasionally a patient is found who apparently does not absorb the sugar solution which is given to terminate the coma. These patients seem to go into an even deeper coma after being given the sugar solution, and if they do not begin to return to consciousness within approximately half an hour, other things being equal, it is usually advisable to give them intravenous glucose, from which they react quite quickly. Often it is noted that when they do start to wake up they vomit the sugar solution. Explanation for this is not clear, but it is suggested that they have considerable loss of tone of the stomach, diminished peristalsis during the coma, so that the sugar solution is not forced out into the duodenum, where it can be quickly absorbed. Usually after a short time they will be able to drink some more sugar solution, but occasionally gastric lavage is necessary. It is interesting that in none of the patients that were observed personally was there any spontaneous desire for food as the blood sugar was becoming lower preliminary to the appearance of coma. However, when they are brought out from the coma with the sugar solution, they are often quite hungry. However, it is quite true that some of the patients after several days of treatment will have a marked increase in appetite not only for the noon meal but also for other meals taken that day, and also on the rest days when they receive no insulin. There are those who feel that the gain in weight that the patient shows during the treatment is a

good index of the amount of improvement shown. However, this is denied by others who find that most of the patients gain weight whether they improve or not. There is occasionally noted during the deep coma, and especially with agitation, incontinence of the feces.

It was found at the Harlem Valley State Hospital by routine morning urine examination that about 50 per cent showed a mild glycosuria even though the previous day they had had no treatment. On one or two occasions a slight trace of albumin was found. Apparently water balance studies have not been accurately done. It seems that this is indicated. One girl was noted to have a slight, but somewhat increasing puffiness of the face, although there was no obvious pitting edema to be noted anywhere. She was given a modified Mosenthal test, which revealed one of the specimens to have a specific gravity of 1.028, which was thought to show adequate concentrating ability of the kidneys, considering the fact that there was no well established dehydration before this. There was no nitrogen retention. Another patient at another institution, over a period of about four or five weeks' treatment, gained approximately 25 pounds and then for some reason which they could not explain, in one week lost approximately 13 pounds. Furthermore, Sakel, himself, has said that the gain in weight that these patients make during the treatment may be rather quickly lost after discontinuing it. When taking these facts into consideration with the already mentioned possible changes in the acid base balance and retention of sodium in the tissues, it is highly suggestive that probably a large portion of this gain in weight is in the form of fluids in a generalized subclinical edema which may be quickly lost. Again, it was noticed in another patient who had to void immediately after being brought out of coma, that the urine was basic and in another case the urine was neutral. No control tests have been carried out, but this phase of the metabolic processes may be worthy of further investigation. Certainly, accurate water balance studies should reveal some interesting information.

Many of the motor and neurological changes are well known to all and will only be given here in the merest detail. As is so often found in normal or diabetic individuals who have received an overdose of insulin, there occurs first a certain quieting of the patient, although with some uneasiness, and at this time they may have a feeling of chilliness. Later they really desire to go to sleep in spite of occasional nervousness. At about this time they very frequently appear somewhat pale. There may be beginning perspiration which may go on to a very marked drenching of the patient and the bed clothes. On the other hand, many patients perspire not at all. With the perspiration there is usually a marked increase in salivation, and at this time patients are usually semi-conscious but can be aroused. Usually it is not long before they become actually unconscious and will drool the saliva out of the mouth if the head is turned; the eyes have a tendency to roll from side to side. At about this time there is loss of the abdominal and cremasteric reflexes. From this point on they may remain quiet and go slowly into deeper coma, during which there rather constantly appears positive Babinski, Oppenheim and Chaddock signs, usually increased knee jerks, occasionally true clonus, appearance of the Hoffman sign, finally the loss of the corneal reflex, and when they go beyond this into an even deeper state, there may appear a true areflexia throughout with markedly diminished or absent light reflex. On the other hand, the patient after going into mild shock may not proceed along this quiet course, but rather have a violent and stormy time. There may be marked fighting movements, stereotyped activity such as kicking the legs up and down as if riding a bicycle, or mannerisms of the hands. Again, frequently there is shouting, at which time it is thought from the content of the words that the patient is reacting to some part of his psychosis or conflict state. There is also obscene language used, and forceful spitting out of saliva is not particularly uncommon in these agitated reactions. The third type of reaction which may be associated with the above, but often is not, is one in which there appears in one or all of the extremities first slight twitching of some of the smaller muscles; this progresses to clonic or tonic spasms of that and other extremities, even including the neck, with the production occasionally of opisthotonos. This is allowed to go on for a period of possibly

a half or three quarters of an hour if not too violent. Then ordinarily the patient will drop off into a considerably deeper coma. This is also true of the agitated patients who are shouting and swearing. Usually, it is desirable to allow the patients to go through these active or violent stages if physically possible and proceed into the following deeper coma from which they are terminated by the sugar solution. Of course, it must be remembered that at any time during the course of the hypoglycemia, and particularly during the deep coma stages with the activity noted, that the severe convulsive seizures may be initiated, which are terminated as quickly as possible. The convulsion, of course, is a real threat to life.

It is interesting, as the patient returns to consciousness from his state of deep coma, that the disappearance of the pathological reflexes already referred to often occurs in just the opposite order in which they first became manifest. This is certainly not a consistent finding but is interesting when noted. Thus, among the first abnormal reflexes to be lost often is the Hoffman sign, and the corneal reflex returns while Babinski's sign may still be present, but this latter soon becomes absent as consciousness approaches. Finally the patient may be up and about for almost half an hour before the abdominal reflex returns. No one apparently will definitely make a statement as to whether or not there is any phylogenetic or ontogenetic significance to this appearance and disappearance of normal and abnormal reflexes. However, it has been thought[1] that to some noxious agents the older and more well established parts of the nervous system are relatively immune, but the newer, phylogenetically more recent systems are much more susceptible. The abdominal and cremasteric reflexes, which are among the last normal reflexes to be established in the development of the infant, are the first to disappear during the coma and the last to return after return to consciousness. The corneal reflex, established early in life, is among the last to go and first to return during the same process. The lateral rolling of the eyes may be thought of as a counterpart of a lateral nystagmus—an abnormality of a phylogenetically recently acquired movement of the eyes. This lateral motion is one of the early signs of coma and persists until the patient has almost returned to consciousness. Babinski's sign present in the infant during the first year of life is evidence that the neurological mechanism for the lower leg is not as yet completely established while this mechanism for the arm has progressed much farther. During hypoglycemic shock coma Babinski's sign appears often long before Hoffman's sign and persists longer during the return to consciousness. However, this point of view must be considered as only tentative, for apparenly these relationships are not to be found consistently.

What might perhaps be termed the psychic changes observed during the treatment are, as one would expect, manifold. Perhaps the most constant effect of the insulin hypoglycemia and shock is seen in the lessening of the subjective tension and the quieting of the agitated, disturbed, overactive patients. It may, at this point, be mentioned that insulin has also been used to cut down the psychomotor activity of cases of acute mania.[5] Again it was observed during the shock treatment, even in some possibly borderline cases with very severe psychoneurotic manifestations associated with restlessness and marked subjective tension, that the insulin hypoglycemia had not only relieved the restlessness but showed considerable relaxation of the subjective tension and anxiety, even in the insulin-free periods during treatment. Then again during the hypoglycemia there are in many patients evidences of regression of the psychosis to a former level. Thus, a patient who may reveal considerable confusion, disorientation, with little tangible content to his thought processes, will, during the hypoglycemia, show some clearing of the confusion and a thought content almost identical with the psychosis as it was several months or years before. This may go on so that even during the insulin-free period the psychosis remains in that earlier period. Sometimes with continued treatment, further regression cannot be brought about, but again by continuing the treatment even this may clear up with a favorable result. There often occurs, during the hypoglycemia, a certain apparent lucidity and appreciation of clearing of the thought processes which was not formerly present. Again during the shock, in muttered or shouted utterances, there may be brought to the fore psychic traumata

which occurred years before, even in childhood. At times the patient will state that, when going into the hypoglycemia just before consciousness is lost, he had peculiar visions or sensations which, in their content, may be interpreted as a manifestation of true splitting of the personality. In the type of patient who is variously described as empty, who apparently has almost no thought processes, with no expressed content, who is totally inactive although not necessarily stuporous, there occurs usually during the early stages of the hypoglycemia what is called "activation of the psychosis." That is to say, the formerly empty or mentally void psychotics apparently become stirred up and they begin to move about spontaneously and utter a few words. This, they are encouraged to do by attempted conversation on neutral subjects and even by a certain amount of physical manipulation in an attempt to keep the active process going. In this type of case the patient is terminated early during this activated phase.

Apparently, all patients not only during and immediately after the hypoglycemia, but also during the entire course of the treatment, are particularly vulnerable to psychic traumata which might come from a too inquiring course of questioning concerning some of the more fundamental aspects of their psychosis. This Dr. Sakel feels very strongly and also contends that a consistently hopeful and encouraging attitude should be maintained throughout, for apparently a scientific skepticism can do more harm, at times, than a hopeful optimism can do good.

These varying manifestations of the psychosis may be so handled as to lead the patient out of his psychosis by varying the depth and length of the shocks to which he is subjected, and herein lies the problem. In ideal at least, as the treatment progresses, the lucidity and freedom from psychosis which is apparent during the hypoglycemia, continues on after the hypoglycemia for longer and longer periods until finally the patient is relatively clear all during the day. Then the reverse reaction occurs in which the only psychotic symptoms are noticed during the hypoglycemia. Even then the treatment is continued until during this hypoglycemia little or no psychopathology will be noticed. But this is apparently not a clear-cut progression in actual practice. On the other hand, the so-called empty case becomes activated during the hypoglycemia in the early stages and may remain activated during the rest of the day. As this is a fixation at an earlier state in the psychosis the patient is no longer considered an empty case and treatment is then changed to deep prolonged coma, which is continued as above described for the case in which the psychosis maintains the more dynamic form.

In brief, Sakel theorizes, in part, that the effect of insulin is in putting cerebral conduction paths out of action level by level and that on their recovery the more fundamental normal relationships are assumed.

Dr. Sakel's great forte is apparently being able to determine the optimal time for the termination of the hypoglycemic shock. This, at least from the observations made, is not only a very difficult thing to know, but also is complicated by various factors, for in a rather large percentage of the cases the coma is terminated for purely physical reasons. Thus, there may be vasomotor collapse, marked tachycardia or bradycardia, the respiratory abnormalities already noted, the exhaustion of the patient from his violent overactivity during the hypoglycemia, or the appearance of convulsions. From these manifestations it is obvious that there are certain contraindications for the treatment in the selection of cases. Evidences of cardiovascular disease in the form of hypertension, valvular heart disease, myocardial insufficiency and particularly disease of coronary arteries are felt to be contraindications. However, one or two cases of mild coronary disease have been treated with great care successfully. Any evidences of pulmonary or renal pathology are also felt to make the patients highly undesirable subjects for the treatment. Pathology of the pancreas is also put in the same category, for one of the deaths reported was due to acute necrotizing pancreatitis. Before even attempting treatment it is highly advisable that the patient be a good physical risk. A detail in this regard is perhaps important here; it is highly desirable for obvious reasons that the patient have adequate and easily found superficial veins.

If during the course of treatment, the patient develops for any reason a fever, the treatment is stopped for a few days until this subsides. This is also true of the de-

velopment of albuminuria, jaundice, severe diarrhea or other evidences of active pathology in any of the viscera. Also, if during the treatment convulsions occur, treatment is suspended for at least one day after that. Another complication is "after shock." Occasionally a patient is found who may have his ordinary shock treatment during the morning, be terminated without complications and eat his regular lunch. However, three or four hours after this meal he may again have symptoms of weakness, nervousness, perspiration, and, if not given further glucose by mouth at that time, may fall again into profound shock and need the indicated procedures. This is not an indication for cessation of the treatment the following day, but suggests that the dose of insulin be somewhat decreased. The further details of the special equipment, diet, and special nursing attention, etc., need not be gone into here.

The shock dose as has been stated is a very highly variable one. Marked hypoglycemic shock has been reported from doses as low as 20 units and a case was personally observed in which the dose of 275 units produced only moderate drowsiness with some restlessness and no real coma. Again, cases were found in which the dose of insulin was gradually increased up to 190 units without a very marked effect upon the patient. However, at 195 units rather profound shock was obtained. Merely from an experimental point of view, the dose was then gradually reduced and it was found that in this particular patient 100 units of insulin would produce the desired results whereas during the initial progressive increase in the dosage 100 units produced very little change. Furthermore, other cases which are maintained on exactly the same dose of insulin for a period of time will one day have severe coma, possibly the next day only go mildly into shock and then again the third day may have a convulsion, so that it may be said that there is very little constant relationship to be found between the dose of insulin given and the reactions of the patient. In establishing the shock dose the method of trial and error must, of necessity, be used. Some of those using this treatment institute a variation in which, if after an hour and a half or two hours following the insulin the patient does not appear as if he were going to have as profound coma as desired, a second smaller dose of insulin is given with apparently a rather quick production of the desired coma. Also other supplementary drugs such as atropine have been used during this treatment. However, these technics are very limited in number.

Perhaps a few illustrative cases will help to present a better picture of some of the mechanisms involved as well as the variability that is seen during the procedure.

Case 1.—William W., aged thirty-eight, had apparently been a very adequate individual until about three years ago, although there was a very definite extra-marital alliance. His change in mental activity began about the age of thirty-five, when he became extremely interested in philosophical problems and tried to work out a system of morals which was based somewhat on Einstein's theory of the universe. This created within him a marked state of subjective tension which caused him to become very restless and sleepless. There were only occasional emotional outbursts, but he required fairly heavy sedation at night. He denied hallucinations. He stated that he felt much better after about eight or ten periods of quite deep coma. On going into hypoglycemic coma he often exhibited marked restlessness with a tendency to fight. One morning when he was coming out of the coma, he became unusually agitated and required more than five men to prevent him from falling out of bed and hurting himself. He stated later, "I must have fought all that stuff out of me during the tussle that morning." He was then showing none of the restlessness or anxiety nor did he have the feeling of subjective tension and inability to sleep that he had demonstrated when he came into the hospital. Recently, word has come that after approximately twenty-six treatments he was considered recovered. After a week without insulin he suffered a relapse, but with the resumption of treatment he is again improving.

Case 2.—Another case showing interesting subjective personality sensations is that of Jeroma A., aged twenty-two, diagnosed paranoid dementia præcox of two years' duration. He was rather fearful during the initial stages of the increasing doses of insulin, but finally having reached the dose of 115 units he told of an interesting experience as he was going into hypoglycemia which he remembered the next day. He said that he appeared to be able to see himself as if he were cut into two individuals and that he, the third person, realized that he did not fit into either of those other two individuals, who were also himself. He said he could not explain this. As the dosage of insulin continued to be increased slowly, he appeared afterwards to have longer periods of lucidity with the demonstration of considerable affect. The latest word concerning him shows him much improved although still occasionally hallucinated.

Case 3.—Another case which showed interesting features is that of Robert Van L., aged twenty-two, who was diagnosed dementia præcox, simple type, duration three years or more. At the age of seven he was assaulted by a truck driver in the form of pederasty. This apparently passed without any obvious complication at the time. Later, when sexually mature there was some conflict over an unhappy attempt at sex relations. When treatment was started he was reserved, disinterested and would not talk for long periods. He denied hallucinations at this time. During the beginning of increasing

doses he said that he really felt better physically after the third dose of insulin, which in this case was 45 units. During the fifth injection, which was 70 units, he became rather disturbed during the hypoglycemia and shouted out, "You know what prick the needle means." He also kept repeating that seven was his unlucky number and apparently was in conflict over it. If one is really looking for it one can see some connection here between his remarks druing the hypoglycemia and his being assaulted at the age of seven. He was finally carried on up to deep shock at the dose of 100 units, and apparently has improved some for he is clearer mentally, shows considerably more affect than before and is more interested and active about the ward. When the last information was obtained he was still under treatment.

Case 4.—Sally B, aged seventeen, diagnosed paranoid type of dementia præcox of over one year's duration. Family history is very unfortunate for her in that her mother and her mother's father were both psychotic. She herself was an illegitimate child and has been adopted and raised very carefully by foster parents who themselves are quite unstable. She knows that she is adopted. As a child she is said to have been a sweet and lovely little girl, although she was not bright in school. She is interested particularly in piano and vocal lessons and was sent to a convent school. She is very much more attached to her step-father than to her step-mother and she confided only in him. She was always shy about boys. Separation of her foster parents in 1935 apparently upset her considerably. She became nervous, destructive, irritable, did poorly in school and stated that voices called her a "bad girl." She blocked and was impulsive. At the time of the separation of her foster parents she was urged against her will to sign a paper stating that the foster father, whom she loved, was continually coming home drunk, causing disturbance around the house and maltreating her foster mother, whom she hated. At the time of admission to the hospital she was considered violent, suicidal, very resistive, required tube feeding, continued to be actively hallucinated and required restraint. She would break windows and would occasionally be incontinent. Her thoughts were scattered and irrelevant. When treatment was started she was an extremely resistive, fighting, violent type of patient. After the first three increasing doses she was very definitely quieter, but still when she was brought to the ward she called the nurses "bitches" and continued to spit at them. She did not show this behavior toward the male attendants or doctors. At about the seventh injection, which was of 50 units, she was very much more quiet and cooperative. Quietness continued during the day and after that the resistiveness, spitting, shouting out of "bitch" were only present during the period of hypoglycemia. During the rest of the day she was coöperative and pleasant although very definitely shy, retiring and somewhat unproductive. Through a rather prolonged period in which she remained somewhat the same, it was found that even after her twenty-fourth treatment which had finally been taken up to 75 units, she was still actively hallucinated and Dr. Sakel at that time felt she should be given even deeper coma. He thought that probably the appearance of a convulsion might be helpful in her case. It was a great and delightful surprise to learn recently, by correspondence, that after her twenty-ninth treatment she was considered recovered. This illustrates the quieting of the excited patient with improvement during the day, as well as reactivation of the psychosis during the hypoglycemia.

Case 5.—An attempt at activation of a psychosis was made in the case of Ida S., aged eighteen. diagnosis—catatonic dementia præcox with hebephrenic features, duration three years. In January of 1934 she began to think that men were around her for sexual purposes and that she was going to have a baby. Her appearance became sloppy. Finally she heard voices coming to her through the steam pipes saying that she was a bad girl. She slowly showed less and less activity, became more self absorbed, idle, required spoon feeding, became untidy, sat with merely a blank expression on her face and occasionally showed cerea flexibilitas. She was started on gradually increasing doses of insulin, but they were increased very slowly. After she had had ten injections the dose of insulin had only reached 50 units. She would have to be brought into the ward and put to bed. She would immediately flop down in a characteristic position on her side and only show spontaneous movements of resistance when an attempt was made to give her the insulin. Any attempt to converse with her, to get her to make spontaneous movements or produce change in facial expression were entirely unavailing at this time. However, after about an hour and a half following the insulin, the physician would go in and attempt to talk to her about neutral subjects that might interest her, possibly starting tickling her or moving her about in bed and she would occasionally wake up a little bit, occasionally slap back at him, look with a more intelligent bright expression and sometimes would spontaneously smile and answer in monosyllables. When there was produced as much spontaneous activity as was thought possible during this period she would be given her glucose, which she willingly drank and then she was given her lunch. This case is also still under treatment. In theory it is hoped she can be brought out of her lethargy and fixated in an activated phase.

In regard to the type of case best suited for insulin therapy, it can be said that in general the shorter the duration of the psychosis the better the prognosis and that the paranoid type shows the best results. Dr. Sakel prefers early cases to be under six months duration. A classification of types of schizophrenia with regard to their chances of benefiting from insulin shock therapy and with regard to the kind of shock to be used, follows only in small part a classification based on clinical types. Rather the depth and severity, and the degree of the dynamic manifestations of the psychosis tend to decide the type of shock advisable as well as influence the ultimate outcome, which is also contingent upon the duration of the disease and the patient's response during treatment.

Wilson[13] takes a classification from the literature supplemented by interviews and personal observation of the procedure in continental Europe. She states that the paranoid type most often shows the orderly progressive type of improvement and is greatly benefited by deep coma. When there

are depressive hypochondriacal delusions present in the schizophrenic, the outlook is less favorable and the course during treatment more irregular. In catatonic excitement the course is also irregular but lucidity may come suddenly even though the treatment may be of long duration with the careful avoidance of psychic noxæ, hunger excitement and interruption of shock at an inopportune time. In stuporous cases the improvement is not so regular and often a considerable period of treatment is required before activation of the psychosis appears and considerable variation of the degree of shock may be necessary.

She gives the opinion of the European workers as being that they really cannot say that any particular group of patients will or will not react favorably and that in an individual case prognosis must be guarded until after treatment has begun.

The extent to which this treatment is being carried out in this country is at the present time almost impossible to determine. Of the known cases being treated or having been treated at the Harlem Valley State Hospital, the Worcester State Hospital, New York Psychiatric Institute, Bellevue Hospital, Bloomingdale Hospital, The Phipps Clinic and other hospitals near Baltimore the total is approximately 120 cases.† However, there are probably a great many others being treated that are not included here. This widespread use of the treatment, of necessity divides the entire group up into individually small series of cases in which percentage values are not highly significant. During the six weeks' course when Dr. Sakel was giving instruction at the Harlem Valley State Hospital twenty cases were treated. At the end of this time there were nine cases which were considered sufficiently improved to be at home. There were also nine cases that were thought to be improved but should remain in the hospital. There were two cases which were considered to be entirely unimproved. Of the nine cases that went home, one of them has now returned for further treatement. Another case is reported as still showing very definite paranoid ideas while at home and the relatives find some question in their minds as to whether or not she should return to the hospital. Two of the cases are thought to be very much improved and have remained out of the hospital for approximately four months and are making a good adjustment at home. Another case is particularly interesting in that he is one of a pair of identical twins. In these two individuals the psychosis showed considerable similarity, not only in content, but also in the time of inception. The brothers came into the hospital only a few months apart. One brother is now home, having received the treatment, and making a fairly good adjustment. The other brother is still in the hospital and did not receive the treatment. Of the nine improved cases that had to remain in the hospital, six of them were being given their second course of treatment. Apparently, this second course is but slightly more beneficial than the first. In other hospitals visited, where groups of twenty and twenty-five cases have been treated or are still being treated, various results are given. In one place they may feel that two or three cases showed a very remarkable recovery, approximately four or five others showed definite improvement and the rest considered to be unsatisfactory or are still being treated. These are the usual results although in one hospital they report eight out of ten to show excellent improvement.

Apparently, most observers agree that the time has not yet come when we can in this country fairly judge of the benefits of this form of therapy. Almost everyone in charge of treatments agrees that he is still feeling his way and is very interested in having more cases treated so that a more accurate opinion can be formed. Furthermore, there is a great amount of confusion concerning the whole problem. It is not unusual even among competent psychiatrists to have less than 80 per cent agreement as to whether or not schizophrenia is really present. Certainly there are many cases in which there would be a wide divergence of opinions as to the diagnosis. Furthermore, on top of this there is apparently considerable disparity in opinions as to what is and what is not clinical improvement. Dr. Sakel spoke of patients returning to work who were better suited for the job than they ever had been before in their lives. From here we may go on down to a very slight improvement in which the

†The present estimate of number of cases treated throughout the United States and Canada is now probably well over 600 cases up to January, 1938.

patient who formerly was entirely stuporous had to be tube fed, can now feed himself but is otherwise practically the same. Certainly there is a large variable subjective factor both in making the diagnosis and in judging the amount of improvement that occurred. Furthermore, there is apparently very little agreement as to just what coma is or how far down the line of unconsciousness the patient has to progress for coma to exist. At one hospital when the patient's eyes have begun to slightly roll from one side to the other, when he refuses to swallow and when the saliva, which may be slightly increased, drools out of the side of his mouth he is considered to be in fairly deep coma. On the other hand, it is very obvious that Dr. Sakel does not mean this but feels that coma has not become actively manifest until there are signs of changes in the reflexes. Sometimes he even wants coma deepened up to the time of the loss of the corneal reflex. Certainly, there is great confusion at present not only of opinion but even of terminology and definition, which is further complicated by the individual variations of the so-called Sakel method as seen in different hospitals. The various factors which Dr. Sakel himself stresses, of the optimum time for terminating coma and the kind of coma desirable, add other features which will make reported results difficult to compare.

Possibly, an objective way for controlling some of the variable factors will come out of the use of the electro-encephalogram which has been employed at the Worcester State Hospital and elsewhere for a considerable period of time.[7] This machine, to describe it in a highly superficial and inadequate way, is somewhat analogous to the electro-cardiogram in that it appreciates and magnifies changes in electrical potential within the mass of an organ. With the electro-encephalogram there is measured the changes of potential that occur in the brain as manifested in a certain portion of it. It is a very delicate and variable kind of measurement, but apparently in well controlled work shows definite differences between the normal and the schizophrenic. In taking readings with this machine during insulin therapy they find a very distinct change as coma appears. This change apparently does not vary markedly with the increasing depth of the coma, but is immediately brought back to almost the former level in certain respects upon the administration of glucose and as the patient returns to consciousness. It is found that the tracings taken before and after the treatment with insulin show a difference in that the latter more closely approaches the normal than the former. Furthermore, as the treatment goes on, the tracings become more and more like the normal. They have one case which is far from conclusive evidence, but none the less of a high degree of interest. This individual was treated with the insulin shock method and improved clinically and this was reflected in the electro-encephalogram. Since that time he has been at home at work and occasionally returns to the hospital for monthly supervision and the tracing is taken again. Apparently, before clinical relapse is evident, the electro-encephalogram will show some small but definite changes which are suggestive that the schizophrenic process is returning. This has been confirmed by subsequent actions and symptoms of the patient. He is then given one or two shock doses of insulin, whereupon the clinical improvement is evidenced. The electro-encephalogram shows a return toward the normal and he is again sent out for a month or so to return and have the process repeated if necessary. This machine, of course, is still in its embryonic stages, but will be worth following as a possible mechanical means of helping us out of the difficulties into which our subjective reactions cause our opinions to be tangled.

There is, perhaps, only one observation to be made from a survey of this great mass of variable factors in which the treatment is now steeped, especially in this country. It is possibly the newness and inexperience with the treatment in this country that is responsible for the relatively poor results when compared with the European reports. It is quite true in general that those beginning with this treatment have great anxiety and fear concerning it for the patient and do not dare to carry on the coma to the depth that Dr. Sakel might desire. Satisfactory results seem to be almost in proportion to the depth of coma. Thus, Dr. Sakel and his group get the highest percentage of good results. Those in this country who most closely approximate him in the depth of coma attempted, get better

results than those who follow Dr. Sakel's method only but slightly in regard to coma and get probably the poorest results. Possibly this is a true observation, at least it is apparent at this time.

We have been so conditioned against allowing insulin shock to occur and especially against its continuing in the treatment of the diabetic that it is only with the greatest difficulty that we as physicians will allow ourselves to stand idly by and watch our schizophrenic go deeper and deeper into coma when we have ready at hand an easy means of preventing it. Yet, in certain cases it appears that this deep coma is the most beneficial. Finally, it can be said that in addition to being in many instances a real threat to the patient's life, the procedure is a highly individualized one which must take into account the particular responses of the patient and must be varied in so many ways that in the end only experience can indicate the best path to follow. This experience requires time, and time alone will show us not only the final benefit to the patient, but also the ultimate place that this procedure will hold in the field of therapy.

The author wishes to express his gratitude to the various men mentioned at the beginning of this paper who have willingly given of their time to explain the treatment and tell of their experiences with it. He is particularly indebted to Dr. John R. Ross, Superintendent of the Harlem Valley State Hospital, for his unusual spirit of coöperation in not only allowing the author to use the case history material included in this report, but also extending to him the privileges of the Hospital for a three weeks observation of the treatment there. Many thanks are due to Drs. Gaulocher, Rossman, Cline and Schwoerer, who are personally carrying out the procedure at the Harlem Valley State Hospital, for their interest and patience in demonstrating and explaining the details of the treatment as well as for their coöperation in keeping the author posted from time to time of the progress being made in the patients that were observed there.

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Tracing of Syphilis Through Common Ailments: Clinical Lecture at Atlantic City Session

A. Benson Cannon, New York (*Journal A. M. A.*, July 31, 1937), points out that the present study was originally conceived as part of a larger one dealing with the accomplishments of arsphenamine, in the treatment of syphilis of all stages. For this purpose a systematic record was kept of all adult patients admitted to the department of dermatology from the spring of 1935 to the spring of 1937 whose ultimate diagnosis was syphilis. In the course of this study it became increasingly apparent that a large proportion of the patients so admitted arrived in this department by accident rather than by design, having presented themselves originally for some complaint totally unconnected with syphilis—at least in their own minds and frequently also in the opinion of the admitting physician. The approximately 600 cases of syphilis recorded to date are unselected, then, as regards latency and represent all syphilitic patients who were treated with arsphenamine during any or all of this period. It leaves out of account those who received only intramuscular injections and/or silver arsphenamine. Among these 600 cases there were 300-odd admissions in whom active syphilis was not at first suspected. Not until commonplace injuries failed to heal after weeks or months of treatment by ordinary measures were some of these patients discovered to have a positive Wassermann reaction and some a history of a previous infection, overlooked or passed by as irrelevant to the present complaint. The mystery of the slow healing operative wound—even after the extraction of a tooth—is often solved by the simple procedure of taking a blood test. It was found that a surprisingly large proportion of these patients had presented as their chief complaint some ailment commonly encountered in general practice under the names of gastro-intestinal disorders, chronic disorders of the respiratory tract, urinary symptoms, gynecologic ailments and miscellaneous arthritis, diabetes, hernia, goiter and the like. The present report attempts to describe, in a selected group of cases, the methods by which other causes were eliminated, and the symptoms were traced to a syphilis heretofore either unsuspected or supposedly inactive. Symptoms which brought patients to the clinic, the diagnostic procedures, including laboratory tests, x-ray examinations and pathologic changes, the evidence for syphilis and the treatment and its results are described by the author in the hope that this approach, by symptoms rather than systems (the usual textbook method), may prove of considerable interest and some practical value.

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"Every man owes some of his time to the upbuilding of the profession to which he belongs."

—THEODORE ROOSEVELT.

EDITORIAL

TREATING MIND AND BODY

THE leading paper in this number of THE JOURNAL, by Dr. Reynolds of Boston, discusses an interesting, if not a somewhat neglected, phase of medical practice. Time was when the family physician knew not only the organic ailments of his patients, but also their environment, particularly such obstacles to mental well-being as perverse "in-laws," so that he was able to estimate, in a crude way, how much of the ailment was due to a disturbed digestion and how much to an obdurate mother-in-law, as the case may be; in his ministrations to the patient he prescribed accordingly. The modern, up-to-date doctor, while more scientific than his ancestor in the profession, has not had the same opportunity to become acquainted with the environment of the patient. Sometimes obscure or atypical gallbladder symptoms or those suggesting peptic ulcer can be cleared up under an ideal mental adjustment.

Dr. Reynolds, in two or three cases cited, shows the effect of environmental factors upon not only the mental but the physical health of the patient. For the busy doctor, the patient's background may be studied by a trained social worker. It would be ideal if this were possible; and doubtless in clinic groups, it may be found satisfactory. However, with private patients, we fail to see how this duty can be relegated to anyone else. By judicious questioning, the doctor should, however, find out for himself the patient's mental reactions, for patients are apt to be reticent in the presence of third persons. Of course, a thorough physical examination, together with all indicated laboratory aids, must be performed and the possibility of any organic lesion eliminated before one is justified in assuming that the trouble is entirely mental. A competent physician will not pass up the patient in whom he fails to find any positive evidence of disease. He should act as father confessor if he has the confidence of the patient. Patients are often greatly benefited through what has been aptly termed mental catharsis. The doctor need not be a psycho-analyst or a psychiatrist to render important service to his patient. In fact, the general practitioner in whom the patient has confidence is a much greater physician than the skilled psychiatrist who may be a stranger.

Dr. Reynolds' paper is a plea for a close study of environment factors, as well as an intimate knowledge of the patient's physical condition, which may now be presumed to be recognized and treated seriously by the majority of physicians.

COOPERATIVE MEDICINE

FROM Ann Arbor is announced a half-baked plan for the coöperative practice of medicine. The University Medical School and the University Hospital have nothing to do with it and, so far as we know, the University is not concerned with it at all. The plan roughly, as announced in the newspapers, is to collect from each of 200 or 250 families, twenty-five dollars.

For this, the family member is to receive all necessary medical care for one year, including medicines. Confinements, where indicated, are to be ten dollars each. While the scheme was incubated and hatched in the mind of a non-medical instructor, as mentioned, it is apparently a purely individual matter so far as the authors of it are concerned.

We are not going to attempt to criticize it. So far as the medical profession is concerned, each member has his own attitude toward such movements. That attitude may be prompted either by experience or surmise. The coöperative medical service idea is contrary, however, to a large portion of the favored methods of medical practice.

Regarding coöperative movements of any kind, our experience is, of necessity, limited and our knowledge is mostly the result of reading. Most of the schemes proposed in the United States have been those employed with greater or less success in European countries. Even though they may work satisfactorily in Europe, there is no assurance that they would be satisfactory here.

However, almost while in the act of reading the newspaper account of the Ann Arbor plan, the *Manchester Guardian* arrived with an article* on the coöperative movement in Great Britain.

"Everyone who looks at the coöperative movement," writes the *Manchester Guardian* reviewer, "with a sympathetic eye or knows anything of its remarkable history over the last century must have the feeling that there is something wrong with it, that it is not half as good as it ought to be. . . . Yet it does not play the part in the national life that one would expect from its size, its financial strength, and its considerable tincture of practical idealism. It throws up few or no national figures known outside its own ranks. The cynical are often heard to marvel at the miracle that a movement so shot through with mediocrity should yet flourish with such success. . . . Why, with a membership covering half the families of the country, does it only do a ninth of the total trade? The inquiry set out to find the explanation. It is a hard saying, but largely true, that the coöperative movement does not know where it is going. It has failed to work out a new philosophy of coöperation after the older Owenite ideal has been abandoned, and its influence in the realm of ideas has, in modern times, been negligible. Educationally also the movement has lost its way. After many decades of much valuable achievement the movement has reached a phase where the original impetus has worked itself out. . . . Then, again, the coöperative press lacks distinctive character. Many coöperative journals are unworthy of the movement they represent. They are dull, unattractive, lifeless, and frequently unreadable without a great effort. . . . Cooperators will not get the best because they will not pay for it and are too self-satisfied to know how to get it. Again and again it is pointed out how the movement fails to attract and keep the best brains."

These criticisms give a fair idea of the working out of the coöperative idea in Great Britain where the movement is long out of the experimental stage. It has been in existence in England about a century and today has seven and a half million members. Its finances are estimated at $900,000,000.

Carry the coöperative idea into medicine as publicized by the Ann Arbor proponent and what guarantee have the coöperative families that the result will be any different from the experience of Great Britain.

The commodity one purchases is just worth about what one pays for it, or less, unless supplied gratis. Bargains are few and far between, whether medical service or a pair of shoes. Besides, none of the proposed plans reaches the indigent, who will continue to be the care of the medical profession.

*Consumers' Coöperation in Great Britain; An Examination of the British Coöperative Movement: by A. M. Carr-Saunders, P. Sargent Florence and Robert Peers. Allen and Unwin. Regarding this book the *Manchester Guardian* writes: "During the last few years, a committee of economists and educationalists has been engaged on an inquiry into the British coöperative movement. The inquiry has had the goodwill and assistance of the movement, and the results are presented today in a book that should earn the gratitude—when they get over the shock—of all cooperators. The work of writing the book fell to Professors P. Sargant Florence, R. Peers and A. M. Carr-Saunders, but they had many assistants among research students at various universities. The result is a book of over 550 pages covering all phases of the movement and certain to have wide influence." The complete review from which these sentences were taken will be found in the *Manchester Guardian* of Jan. 28, 1938.

FEWER, NOT A GREATER NUMBER OF DOCTORS

EFFECTIVE organization produces efficiency and the tendency of efficiency is to dispense with man power. Socialism, or a socialistic state, represents the highest form of organization and control. Coöperative societies, while not the fruit of socialism in the true sense, are nevertheless socialistic, even though they are voluntary organizations. Our concern is regarding the subject of medical services on a coöperative plan. In some European countries, notably Norway, Sweden, and Denmark, such cooperative societies are beyond the experimental stage. We have been told that instead of fewer doctors, we would require a great many more doctors than are now practicing in the United States, were the United States to become a coöperative society on a large scale. The number of doctors per unit of population in the United States is

approximately one to seven hundred. In those Scandinavian countries which have adopted a coöperative system, we would expect a greater number of doctors per unit of population than we have in the United States. As a matter of fact, the reverse is true. Holland has one doctor for 1,417 of the population, Norway has one doctor for 1,555 and Sweden has one doctor for 2,660 of the population. This is what we would expect inasmuch as no doctor outside of the coöperative society would have any decent opportunity to earn a livelihood. We were further told that a doctor in a coöperative society is so envied by those outside that there is a waiting list of the best qualified men for salaries ranging from $2,000 to $5,000 a year. Naturally the positions would be attractive at almost any salary if the coöperative society included all or most of those citizens who were able to finance themselves. We are not told what becomes of the indigent sick. Who renders them medical care? Is it the doctor who is outside of the coöperative unit? The medical profession have rendered medical care to the indigent sick not only in free clinics but in their private offices. There is a feeling that such persons are no longer a burden on the community, so that socially inclined persons turn their attention to those who are able to pay for ordinary medical care.

The medical profession is not blind or deaf to the growing tendency towards centralization whether it be state medicine or coöperative medicine. This tendency is apparent to all. We are not attempting to criticize so much as to get at the facts. So far as we can learn of any of the collective plans of practice, fewer rather than a greater number of physicians will be required.

STREET ACCIDENTS

THIS is an inexhaustible perennial subject for discussion. Furthermore, it is a medical subject involving both prevention and treatment. It is too much to expect that all accidents may be prevented by drastic rules and punishment. The human personality must be reckoned with. Many drivers are border line psychoneurotics; under ordinary conditions, they get by, but in an emergency they fall short and accident results.

Last year 40,000 persons are reported to have been killed and more than a million injured. Road traffic has produced fatalities almost as numerous as war. To reduce the number of accidents by insisting on safety of cars, in nineteen states, automobiles are subject to rigid and periodic inspection which includes lights, horn, windshield wipers and rear view mirrors, brakes and tires, steering wheel, exhaust line, gasoline and ignition systems. This is to be commended; not only does it make for safety of the automobile itself, but the driver is made safety conscious.

This is pre-eminently an age of speed; it is also an age of distances which must be covered in the shortest possible time. Many refuse to heed the old maxim, that carries with it so much truth, "Don't hurry for you have no time to lose." Sixty miles an hour means eighty-eight feet a second. The reaction time of a normal person to an external stimulus, either hearing or seeing, is said to be about a fifth of a second. With some it is slower than this. In a fifth of a second, one has travelled about eighteen feet if his automobile is going at the rate of sixty miles an hour. How important it is then that the car be mechanically perfect! Not only this, but how important also that the driver know himself and take cognizance of his surroundings before he attempts such speed.

The drunken driver is a menace to road safety. Stiff fines and prison sentences should inspire in him a wholesome regard for the rights of others. The thoughtless driver, the driver with atrocious manners who has no regard for the rights of others, is also a nuisance; he makes hairpin turns on a busy street without signalling those behind him. He is met when he suddenly makes a left turn for a cross street in front of oncoming traffic, trusting to luck to make his destination without being struck. In war, such a spirit might be called heroic, for the "hero" would be taking chances with his own life only; in traffic it goes by another name, which would not look well in print.

Consideration for the other person and plain good manners would have saved a large number of the forty thousand slain on this continent last year.

ROLLIN HOWARD STEVENS HONORED*

"One of the most active and vigorous figures in the practice of American radiology today is that of Dr. Rollin Stevens who now has reached the age of three score years and ten prophetically signalized in Scripture writ and whose enthusiastic sedulous and forthright individuality, crystallized in the service of mankind and polished by the gentle contact of each passing year, continues to reflect from its many facets his faith in his work and in himself in the doing of it as well as the joy of fulfillment which the realization of his life's ideals has assured to him."

SO RUNS the opening paragraph of a tribute to Dr. Stevens by Dr. Percy Brown of Boston in *Radiology* for January. Those of us who have known Dr. Stevens as a fellow member of the Wayne County Medical Society, as well as special societies to which many of us belong, feel that Dr. Brown has not only expressed his own kindly feeling, but the attitude of all Dr. Stevens' numerous friends, both within as well as outside of the medical profession. A great many complimentary statements could be made about the doctor as a man and as a member of a pioneer specialty, for he has seen radiology grow almost from its infancy. However, in Detroit and Michigan, his work is too well known to require it. He has been a lifelong student and his interests have transcended his office. Dr. Stevens is well known nationally for his work, which is aimed to advance the standard of radiology both in the domain of treatment and diagnosis. He is one of the founders (and is still a member) of the American Board of Radiology, the purpose of which is to certify to the qualification of specialists in x-ray diagnosis and treatment.

Dr. Stevens is a prolific writer. His bibliography comprises fifty-five titles. Entering the specialty of radiology by the dermatological route, his contributions on radiotherapy comprise a majority of subjects of his pen. He has not only pioneered in radiotherapy, but he has interested himself particularly in the radiation treatment of malignancy.

A man with a cultural hobby (and Stevens has several) never really grows old. The doctor is even a specialist on mushrooms (we have never learned the botanical term for them), but the fact that he has attained his three score and ten is proof that he knows his subject. Dr. Brown's interesting sketch of Stevens presents a full page of pictures on the subject from boyhood showing the evolution of the doctor. With advancing age, he retains a heavy shock of hair; the only change is a silvering as the years are numbered; in no sense the glabrous dome commonly associated with wisdom. In this, Dr. Stevens is the exception. This is too bad, for

> After all is said,
> There is nothing like a bare and shiny head.
> Age lends the graces that are sure to please,
> Folks want their doctors mouldy like their cheese.

*Dr. Stevens was tendered a complimentary dinner by the staff of Grace Hospital, Detroit, on January 29, 1938, in honor of his seventieth birthday. See February Journal, M.S.M.S., page 195.

MENTAL HYGIENE

"This is the greatest error in the treatment of sickness, that there are physicians for the body and physicians for the soul, and yet the two are one and indivisible."

This statement was first made by Plato over two thousand years ago and it has been made in substance, if not the exact words, many times since. Yet there is an attitude among many of us who care for the sick, which maintains that the absence of organic disease justifies us in the belief that there is nothing much wrong with the patient. Of course, the first thing to do when confronted with the problem patient is to make a thorough physical and laboratory examination. If this examination is thorough enough, and in the end reveals no physical lesion, then the physician should go farther. Mental ailments are as real as (sometimes they may be more so than) physical ailments. Shakespeare once said, "There is nothing good or bad, but thinking makes it so." If thinking makes a lesion, real or apparent, severe, then must the physician do what he can to "minister to a mind diseased and pluck from the bosom a rooted sorrow."

The physician in general practice is the first line defense in warfare against disease. People who are sick seek his aid first. His viewpoint should include mental as well as physical aspects of disease, and he should be prepared to deal with milder cases which require mental hygienic rather than institutional treatment. Often his rôle as father confessor, as a sympathetic listener, is all

that is required, and a mental catharsis may prove entirely salutary to the patient.

Conditions under which we live at the present time are trying. When men's lives are geared to the tempo of the machine age, something, somewhere, is apt to break. The field for mental hygiene, considering this fact and the fact of economic insecurity, is forever widening. If we may conclude as we began, the physician for the body and the physician for the soul should be one and the same person.

INSCRIPTION BY JOHN McCRAE

This inscription on the fly-leaf of the post mortem record book of the Montreal General Hospital for 1902-1903 was written by Dr. John McCrae who was pathologist there at that time. It passed unnoticed for over twenty-five years and was only recently discovered when the pages were separated. The inscription which was first published in the *Canadian Medical Association Journal,* April, 1937, reads thus:

"Here begynneth ye Booke of ye Deade,
wherein is fayrely set foorth ye last state
of four hundred and seventeen persones,
tht have departed this lyfe; wherein be
tabled diverse strainge and fearsome condicions
tht have ledde to ye same final ende; God
have them of his grace."

There follows a quotation:

"'Our lyfe is but a Winter's Day.
Some only breakfast, and away.
Others to dinner stay, and are fulle fedde.
The oldest man but suppes, and goes to bedde,
Large is this dette, yt lingers out the day.
He that goes soonest, hath the least to pay!!'"

From Horae Succisivae

By Joseph Henshaw, Bishop of Peterboro, 1661.

The editor is indebted to Dr. W. H. Marshall of Flint for this interesting verse.

STATE MEDICINE IN MICHIGAN

"Physicians interested in obtaining positions in Michigan state hospitals and institutions are invited to compete in an open examination March 19 by the Michigan Civil Service Department. Residence requirements have been waived and all qualified citizens of the United States are eligible. Examination centers will be established in Michigan and in cities throughout the United States wherever there are sufficient applicants. The examination is being given to establish an eligible register from which names will be certified to fill present vacancies in the state hospitals. It is open to physicians not over thirty-five years of age who have been graduated from a medical school of recognized standing, who have a license to practice in Michigan or a license from a state with a reciprocating license agreement, and who have had one year of rotating internship in an approved general hospital. The tentative salary for the positions has been set at $180 per month with certain deductions for maintenance.—From a news item in the *Journal A.M.A.*

The Editor's Easy Chair

USEFULNESS OF USELESS KNOWLEDGE

THE tendency of education for a number of years is to fit young people for the task of earning a livelihood or of earning a better livelihood than would be possible without it. This is, in a sense, commendable. Often statistics are pressed into service, the purpose of which is to show that persons with a high school education can command a higher salary than those without it; and that those with a college education are better paid, by and large, than those who enter upon a life work with a high school education. Such are the inducements held out to young people to pursue higher learning. Considering the plethoric conditions of high schools and colleges, statistical propaganda have been successful. This idea of education is not new. Thomas Carlyle, the English sage of the last century, deplored the idea prevalent in his time to the effect that parents wanted to know what education was best fitted to enable their sons to "drive a gig." This seemed to be the chief desire of the days when most people walked. John Ruskin, a contemporary of Carlyle, regretted the tendency on the part of parents to seek for their sons and daughters that particular education which would enable them to ring the front door bell of the houses of the great rather than the bell to the servants' entrance.

In other words, emphasis was and still is placed upon an education that would enable one to earn a living, rather than that which would enable one to live a life of fullness.

Those of us who are familiar with Conan Doyle's works, will recall that Dr. Watson took inventory of the knowledge of Sherlock Holmes and found that Sherlock Holmes was very proficient in those branches of erudition such as chemistry and geography which helped him as a detective, but his mind was blank on all that did not minister to his immediate occupation. Dr.

Watson endeavored to supply the deficiency by giving information on those subjects in which the great detective was weak or wholly wanting, only to be met with the reply that, "Now that I know these things, I shall immediately proceed to forget them."

There is a kind of knowledge that is wholly unnecessary for earning a livelihood, that is, very helpful in the art of living well. We will call it useless knowledge so far as the acquisition of an income is concerned. A physician, for instance, will find the subjects included in the medical curriculum of immense value to him in the practice of his profession. Music, literature and art for him fall into the category of useless knowledge. The musician, artist and writer would place the subject of pathology or anatomy in the same category, and yet there are probably few things more satisfactory to the doctor in his off moments than an appreciation of music, literature, or art, or any one of them; likewise the artist, the musician and the literateur might delve into physiology or anatomy to their personal advantage. The mind cannot rest or one's mental powers become renewed by mere passivity. Some select golf and other sports. Some pursue a hobby of some sort, useless so far as making a living, but very useful so far as giving satisfaction in life is concerned. Useful knowledge is a necessity; useless knowledge a privilege.

Someone has defined that elusive thing called culture as knowledge outside or apart from one's regular vocation. In other words, a knowledge or appreciation of art or literature would make a doctor a cultured man, or a fairly accurate, though not necessarily extensive, knowledge of physiology or anatomy would entitle the artist or musician to the same reputation. In other words, culture is defined as an acquaintance with departments of knowledge outside of one's vocational studies. There is an idea worth pondering over in this, though we do not offer it as the best definition of culture.

A great many of the leading physicians are fully cognizant of the importance of this socalled useless knowledge. Among them we might mention Osler, Weir Mitchell, and Oliver Wendell Holmes. Many other physicians have actually won renown in fields apart from medicine. Their work is described in a fascinating little volume on the subject, Medical Truants. So-called useless knowledge has been appreciated by many of our profession whose names are not recorded on the Bede roll of fame.

The Ancient Greeks claimed that one must live before he could live well. The cultured Athenian had a system of slavery whereby the helots or Greek slaves performed the menial tasks so that the masters might devote themselves to those pleasures of the mind such as philosophy, art and rhetoric, which meant living well. Many moderns spend so much of their time in living that they forget the real object for which they are working, namely, to live well by enjoying the cultural opportunities that may be had for so little effort. They are interested in the acquisition of things rather than in pursuits that provide so much satisfaction. The word amateur, which ordinarily carries with it the idea of novice, and therefore inexperience, has a much different meaning. The amateur is one who does things entirely for the love of it (recall your Latin).

We have used the word "physician." Any other profession, law, engineering or teaching might be substituted. To any of these, so-called useless knowledge would be that which does not minister to their immediate calling. The writer knew a retired banker whose hobby was English and American history which he had mastered in the minutest detail. Though he attained his four score years, he never seemed to be an old man. "Age could not wither nor custom stale." Hobbies of various kinds may be listed in this class. It is not necessary, however, to argue with the hobbyist as to the value of the mental effort he devotes to those things which are outside of his means of earning a livelihood.

Acquiring Fluency—Jones: "How is your son getting on at college?"

Smith: "He must be doing pretty well in languages. I just paid for three courses—$10 for Latin, $10 for Greek, and $100 for Scotch."—*Empire Review.*

Crushed—"Don't you think she looks smart in that dress?"

"Yes, but her hat looks as if it had made a forced landing."—Halifax *Chronicle.*

POSTGRADUATE PROGRAM FOR 1938

Michigan State Medical Society—University of Michigan—Wayne University

The Department of Postgraduate Medicine of the University of Michigan Medical School, in conjunction with the Wayne University College of Medicine and the Michigan State Medical Society, announces the following short, intensive postgraduate courses:

Annual Spring Courses

Ann Arbor

University Hospital

Electrocardiographic Diagnosis	April 4-9
Ophthalmology and Otolaryngology	April 25-30
Diseases of Metabolism	May 16-18
Diseases of Blood and Blood-Forming Organs	May 18-20
Roentgenology	June 27-Aug. 5
Pathology (four courses of two weeks in special subjects)	June 27-Aug. 19
Laboratory Technic	June 27-Aug. 19
Summer Session Courses	June 27-Aug. 19

Detroit

Pediatrics (Henry Ford, Children's and Herman Kiefer Hospitals)	April 18, 19 and 20
General Medicine (Receiving and Herman Kiefer Hospitals)	April 18-22
Proctology (Receiving Hospital)	April 25, 26 and 27
Urology (Receiving Hospital)	April 28, 29 and 30
Obstetrics, Gynecology and Gynecological Pathology (Receiving and Herman Kiefer Hospitals)	May 2-6

Consult Your Bulletin for Details.

Annual Autumn Courses

The following subjects will be presented in the autumn Extramural Courses:

Gynecology and Obstetrics

1. The management of hemorrrhage in pregnancy.
2. Evaluation of methods of management of pelvic inflammatory disease.

Surgery

3. Demonstration of the treatment of varicose veins and ulcers of the leg. The early and late cases.
4. Care of fractures of long bones.
5. Abnormalities and diseases of male genital tract.

Internal Medicine

6. The differential diagnosis of persistent cough.
7. Methods for diagnosing fever of unknown origin.
8. The prognostic significance of the white blood cells in infections.
9. A rational classification of nephritis and principles in management of the nephrides.
10. The significance of the cardiac arrhythmias.
11. A demonstration of the newer important laboratory aids for office use.
12. The criteria for the diagnosis of tuberculosis.

Neurology and Psychiatry

13. The care of the aged person.
14. The importance of early recognition of mental disease. The physician's rôle in the statewide program for control of mental disease.

Dermatology and Syphilology

15. The newer methods of treatment of some common skin diseases.
16. Evaluation of the Kahn test in treatment of syphilis.
    Management of latent syphilis.

Pharmacology

17. The indications for use of certain drugs.

Centers

Ann Arbor
Battle Creek-Kalamazoo
Bay City
Flint
Grand Rapids
Lansing-Jackson
Marquette
Traverse City-Manistee
Cadillac-Petoskey

For further information, address:
Department of Postgraduate Medicine
University Hospital
Ann Arbor, Michigan

President's Page

QUALITY MEDICAL SERVICE FOR ALL

I AM going to ask a blunt question: Is your county medical society well organized, doing things and accomplishing good for your community?

If it is organized, you already know the demands of the people, and how your county society and its individual members are trying to meet those demands. You recognize (1) that there is a demand for the continuation of high quality medical service, and (2) that this quality service must be made available and brought within the reach of all.

To a degree, the first demand may be met in a county having fair medical organization, because of the training, education and initiative of the individual practitioner of medicine; but no programs for the maximum distribution of medical service, especially in the newer field of preventive medicine, can be accomplished without the help of a very efficient medical society.

Service to the people implies that every county medical society knows the situation in its county with reference to curative and preventive medicine. This includes the major premise that the practitioners are well acquainted with the latest technics, including preventive medicine procedures, and that there is no medical problem in the community in which your county medical society does not accept leadership: who are better qualified to handle these technical matters than those trained in this particular field?

The layman today is giving a great deal of thought to the question as to whether everyone can obtain, or does obtain, medical service under our present system of practice. I am somewhat concerned at the approach the layman may make: that he may forget quality or may put price foremost, or may forget the value of properly trained practitioners. This indicates the imperative need for accurate and authentic information to the people, supplied by the county medical society.

Every county medical society should sit down calmly and honestly ask itself: "Are the people in this county able, under all conditions, to obtain medical services they need? If not, why?" If any lack is only partially our responsibility, I believe we should meet with all others concerned and discuss the problem. But leadership in medicine is the responsibility of medical practitioners and of their medical societies.

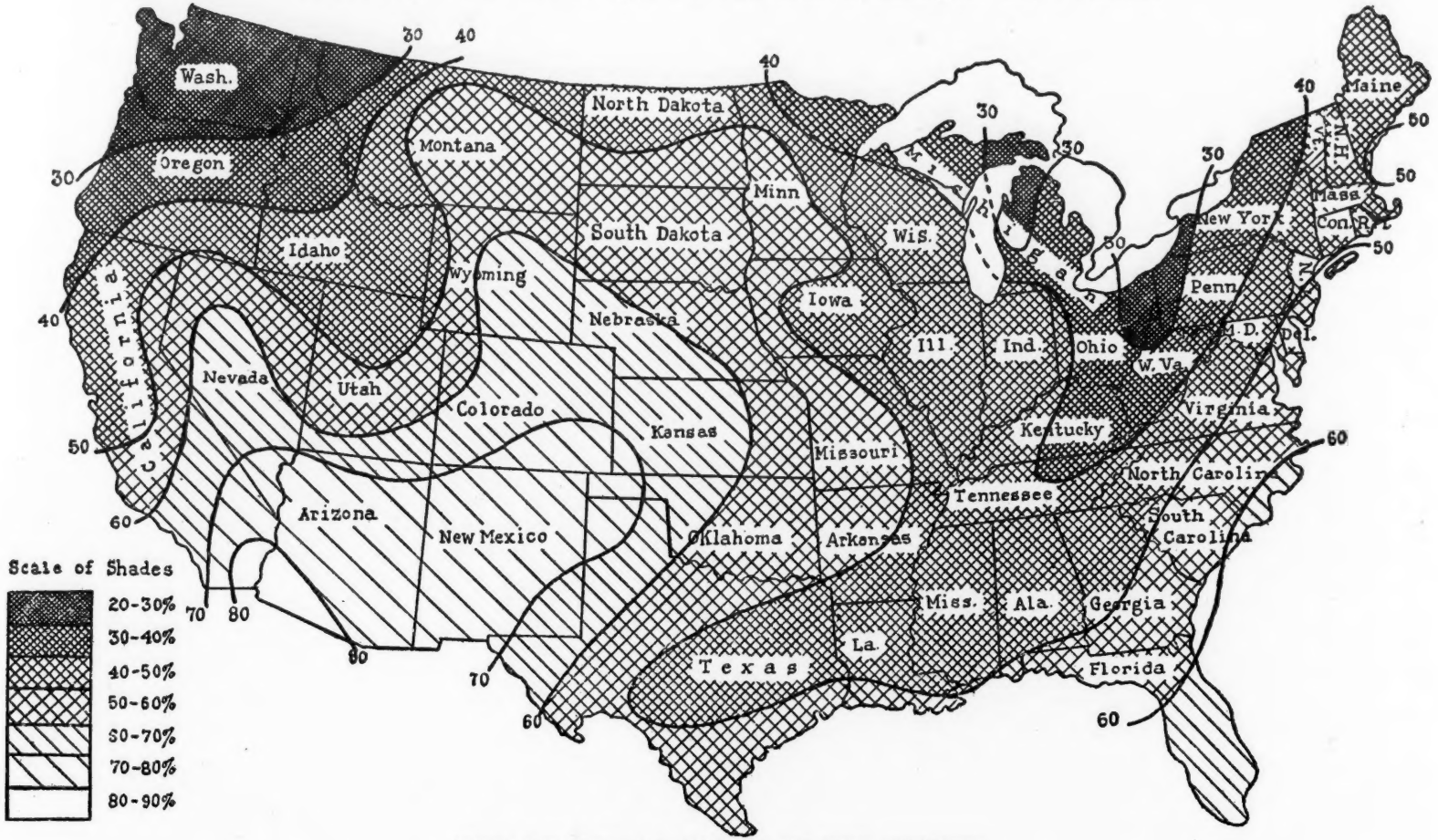
Our present system of private practice, based on the family physician-patient relationship, will be continued when we have done the best job possible in the distribution of the proper quality of medical service.

Respectfully submitted,

Henry Cook

President, Michigan State Medical Society.

Average Percentage of Actual Sunlight in Winter



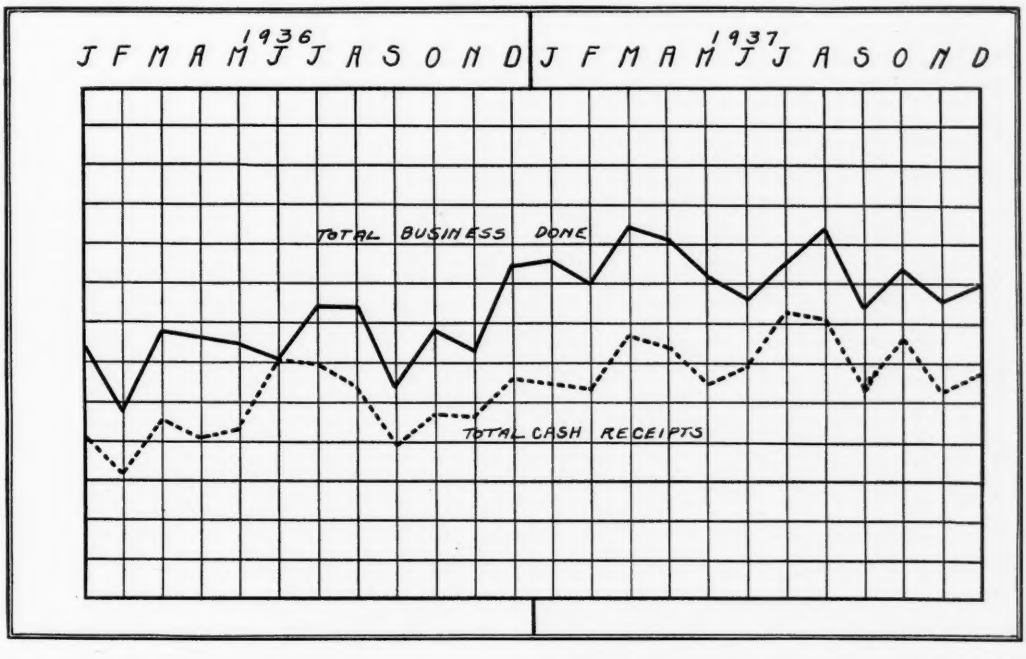
WHY PEOPLE GO SOUTH IN THE WINTER

An increasing number of people are availing themselves of a short winter rest period in the south with considerable benefit to their physical and mental health.

About 70 per cent of the nation's population, largely urban, reside in an area constituting approximately two-thirds of the country and lying north of a line drawn through the southern boundaries of Virginia and Utah. The average amount of sunshine per month during January, February and March in this area is approximately 140 hours, whereas in the nation's principal winter vacation spots, the average is 225 hours.

Whether dwelling in the North or the South each person needs an adequate intake of vitamins A and D. Natola is effective and economical.

This map, adapted from one prepared by the Michigan Department of Health, is reproduced from the Monthly Bulletin of the Indiana Division of Public Health, by permission of Dr. Thurman B. Rice, Editor. Electro contributed through the courtesy of "Therapeutic Notes" (Parke-Davis & Co., Detroit).



"HOW'S BUSINESS?"

By Henry C. Black and Allison E. Skaggs

WHILE no amounts are shown in the graph, each straight cross line represents $100.00. From the monthly figures of well over one hundred Michigan doctors, fifty were selected whose practices were most representative in their community, and the above is a graph by months of business done and cash received, based on this average. These practices include general practitioners and nearly all types of specialization, and are located in various parts of lower Michigan in communities ranging from the largest cities to the smallest villages. It might be interesting to note here that the size of the community seems to have little effect on the size of the income of the physicians practicing in it.

The solid line in the graph is average business done each month and includes only charges made for services whether paid for or not. The dotted line represents the average cash receipts for services each month, whether cash business or cash received on accounts.

Although the scope of the figures available to us does not allow us to draw the conclusion that these are average trends, at the same time we do feel that they represent a fair cross section of the experience of physicians who handle the business side of their practice well. The compilation of these figures was prompted by the varying comments of physicians who frequently remark that, say December, is always a bad month for them; or that collections are particularly good, say in the fall when crops are harvested. Also it was thought that while the effects of the current business recession are being described in relation to other business, the professional man might be interested in comparing his own experiences with a cross section of others in the same region.

We are making no attempt to draw any conclusions from these figures, but rather will point out several interesting facts which exist in the averages obtained for this two-year period:

(1) The month having the highest cash receipts in both years was July, and the lowest February.

(2) December Business and Cash exceeded November's in both years.

(3) Business fell off continuously from

(Continued on Page 273)

DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

PRESS RELATIONS KENT COUNTY PLAN

IN order that there may be better public relations and a better understanding of medical problems in the minds of the public it is very evident that there must be developed between the county component units and the local press a definite set-up of press relations. This has become so apparent that in the larger metropolitan districts the press has appointed science writers to handle questions of a medical and scientific character. It has recently been said, "Medicine is the only profession that is muzzled." The so-called muzzling of the profession has arisen as the result of the Medical Code of Ethics and the reluctance on the part of organized medicine to so publicize its business that it might be interpreted as personal advertising.

There has developed in recent years a very decided demand on the part of the public for more information on matters of medicine and general scientific subjects. Unfortunately, much of the health information that the public has received has emanated from sources other than those of a medical character. It therefore behooves the medical profession to develop a definite press relationship so that the education of the public can be placed on a definite scientific basis. In other words, it is necessary for medicine to interpret itself to the public. The National Association of Science Writers has declared itself in favor of going directly to official committees of County Medical Societies for its information, in order that it may expect accurate authentic information from these groups. It is definitely understood, however, that all such information should be credited to County Medical Societies and not to any individual.

In order to apply in Michigan the principle of better press relations there is being developed in Grand Rapids what is known as the Kenty County Plan. This plan was inaugurated by conferences between representatives of the Kent County Medical Society and the various publications in the county. By a mutual agreement the various Press Associations have decided to contact this committee of the Kent County Medical Society for any information on matters of medicine and health. By conferring with especially designated members of the Kent County Medical Society, it is very evident that the press of Grand Rapids and Kent County will have authentic information on all matters pertaining to medicine and to the general public health of the community.

When the details of this plan and its mechanics for operation have been thoroughly worked out, it is hoped that the Michigan State Medical Society can, through its various component county units, apply the same principle of press and public relations to every community in Michigan. The success of the plan depends, first, upon a cooperative understanding between representatives of the press and those of organized medicine; secondly, there must be developed a very true sense of confidence on the part of both the press and representatives of the medical profession. This understanding and confidence entails on the part of the medical profession a frank discussion of those scientific and health problems that affect the general public; on the part of the press it entails a willingness to determine by conference what facts are of public interest as news items and what facts have no definite bearing on the general health of the community.

With the modern scientifically trained physician and the development of an in-

The Directory Number
May, 1938, Issue

A list of all members of the Michigan State Medical Society (in good standing as of April 1, 1938) will be published in the May, 1938, JOURNAL.

formed public on matters of health and scientific medicine, certain marked improvements are certain to result in both the type of medical care rendered to the people and an appreciation on the part of the public as to what constitutes good medical service and public health.

STUDY OF MEDICAL CARE BY COUNTY SOCIETIES

THE American Medical Association has taken the leadership in encouraging county medical societies of the United States to undertake studies to determine medical needs and to formulate preferable procedures to supply these needs in accordance with established policies and local conditions.

Each of the fifty-four county medical societies in this state, component parts of the Michigan State Medical Society, has been approached to make this important survey, to determine the need, and to supply to the public all necessary medical and health facilities.

The importance of this plan is that the county medical society is asked to assume leadership in its respective jurisdiction.

The outline of this proposed plan for study of medical care is published in the *A.M.A. Journal* of February 12 (page 77 of the Organization Section). An outline of suggestions entitled "Study and Provision of Medical Care" has been sent by the Michigan State Medical Society to every president and secretary of our fifty-four county societies, covering the eighty-three counties of Michigan. The Councilors and Officers of the Michigan State Medical Society urge each county organization to proceed with this important work at once and to carry on until the job is completed. Any and all help will be supplied by the Executive Office of the Michigan State Medical Society, but the important work must be done locally by the county medical society which recognizes and appreciates special problems in each particular jurisdiction.

The Bureau of Medical Economics of the A.M.A. has prepared blank forms to aid county societies in these investigations. These blanks have been distributed by the Michigan State Medical Society.

Throughout the study, the three economic groupings of the people must be taken into consideration: first, the economically comfortable; second, the employed of modest income; third, the unemployed (a) on the welfare; (b) not on welfare.

In "Study and Provision of Medical Care," attention is particularly directed to Section VI entitled "General Consideration," which states in part: "The process of collecting information requires much more than simply 'Yes' and 'No' answers to some leading questions." Most of the desired data will require a search of records to obtain accurate, dependable information.

To the officers of our fifty-four component county medical societies: we urge your coöperation and extreme interest in this study because it will (1) be beneficial to the public; (2) be of value to the individual practitioner; and (3) aid the prestige of the Michigan State Medical Society and its component county societies, already noted for efficiency and medical leadership.

WHAT IS A SOCIAL WORKER?

SOCIOLOGY, or the study of the social sciences, is relatively a new profession in the field of human activity. Social workers have a great deal in common with the true physician, in that they deal mostly in human misery, just as has been the experience of Doctors of Medicine for centuries. Many of their objectives are the same as those of medicine, namely: the restoring to usefulness of unfortunate members of society who have become public charges, and the prevention of others from becoming so—through counsel and guidance. Worthy objectives such as these should be aided by the medical profession wherever possible.

Social workers as a whole represent an earnest, hard-working group. They are just as interested in the furtherance of good medical care for all as any practitioner of medicine. It would appear that the problem of medical service has been approached, in the past, by the medical profession from the scientific standpoint, in that we demand for the people a high quality of medical service; the social worker group approaches it from the standpoint of the distribution of medical service. The coördination of these two aims, and a closer understanding of the sociologists' viewpoint should result in benefit to all. Viewed in the light of reason,

sans emotion, both groups in these quasi-public services—the doctors of medicine and the social workers—are seeking after the same solution of present-day medical problems. Together, these two groups can work out a plan that may lead the way to a better medical policy for medical care of the indigent, including all classifications. Proof that it can be done generally is given in certain county medical societies of this and other states, where good coöperation has been accomplished—to the benefit of the people in general.

NORTHWEST REGIONAL CONFERENCE

THE 1938 Northwest Regional Conference was held at the Palmer House, Chicago, February 13. Members of sixteen middlewest State Medical Societies comprise the membership of the Conference. Deliberations of the Conference, held annually, are devoted to consideration of the economic and social aspects of sickness. General subject of the Conference was "Medical Care for All the People." Specific subjects bearing on the general Conference theme were, "Preventive Medical Care," "Rehabilitation of the Indigent," "Group Hospitalization," and "General Medical Relief." Medical care for all the people was discussed from the standpoint of the American Medical Association, the State Medical Societies and the County Medical Societies.

The Indiana State Medical Society acted as host to the Conference. The sessions were presided over by its president, R. L. Sensenich, M.D., South Bend, Ind. Among the 200 in attendance at the sessions were President Henry Cook, M.D., Secretary L. Fernald Foster, M.D., and Executive Secretary Wm. J. Burns of the Michigan State Medical Society, R. G. Tuck, M.D., Pontiac, Mich., and J. A. Bechtel, Executive Secretary of the Wayne County Medical Society. Dr. R. G. Tuck presented the Oakland County Medical Relief Plan. Dr. Cook, Mr. Burns and Mr. Bechtel participated in the various discussions.

The Missouri State Medical Society will act as host to the Conference in 1939. The officers elected for that year are: Carl F. Vohs, M.D., St. Louis, Mo., president, and L. Fernald Foster, M.D., Bay City, Mich., secretary.

COUNCIL AND COMMITTEE MEETINGS

1. Thursday, January 20, 1938—Mental Hygiene Committee—W.C.M.S. Building, Detroit—5:00 p.m.
2. Saturday, January 22, 1938—Public Relations Committee—Hotel Olds, Lansing—6:30 p.m.
3. Wednesday, Feburary 9, 1938—Executive Committee of The Council—Hotel Pantlind, Grand Rapids—1:00 p.m.
4. Tuesday, February 15, 1938—Contact Committee to Governmental Agencies—Hotel Olds, Lansing—5:30 p.m.
5. Sunday, February 20, 1938—Committee on Scientific Work—Hotel Olds, Lansing—3:00 p.m.

COMMUNICATION

MORE ON THE BRITISH MEDICAL (PANEL) SYSTEM

To the Editor JOURNAL of the Michigan State Medical Society:

"Truth crushed to earth shall rise again," so said the poet; and, I suppose, will continue to arise in spite of being labelled "sub-service."

The starting exposé of the British Medical System, made by Dr. D. W. Orr in the past three issues of *Survey Graphic* should be read and understood by all general practitioners of medicine in this good old U. S. A.

It would seem that Dr. Orr lived at Toynbee Hall (London's Hull-House), and had access to the insured laborers themselves, and to the medical men who work in the System, taking care of these workers.

I speak of laborers because, at the present time, only those with an income of less than $1,250 per year *must* come under the act, and a wife or other dependents are left free to choose any doctor that they can pay privately.

But the worker also has a free choice of doctors; we have been fed the idea that among doctors only the "failure," or the "poor mixer" willingly worked in the System. However, the truth of the matter is that the workers have to select one out of 19,000 British general practitoners who are anxious for the work; further, he can change doctors any time he likes without any questioning; if he complains at treatment received the poor doctor is investigated by a committee of his confreres; in London with *two million* insured and *two thousand* doctors taking care of them, only thirty-four complaints were filed in 1936; and what does *that* record do to the tale that only "failure" doctors come into the System!

A doctor's panel may not be larger than 2,500 insured; the average is considerably less. Suppose you had a panel of 1,500 at $2.25 per year— $3,375.00 payable quarterly—that must include upward of 5,000 dependents for private pickings, wouldn't you feel that you were sitting pretty? Why these doctors make up to $12,000 per year without "surgical fees" and *without worry.*

In conclusion, it would seem that the British public *and doctors* are disgustingly well satisfied with this "Communistic" scheme and are very deliberately working for its spread over all dependents, and to include those with incomes up to $2,000 per year.

C. C. PROBERT, M.D.

Flint, February 14, 1938.

MID-WINTER MEETING OF THE COUNCIL
January 12 and 13, 1938

HIGHLIGHTS:

1. **Annual Meeting, Detroit, September 20, 21, 22, 1938, to feature 30 eminent guest lecturers in seven general assemblies.**
2. **Secretary, Treasurer, Editor, Medico-Legal Committee, Executive Secretary elected.**
3. **Budget for 1938 approved.**
4. **The principle of the Michigan Health League's constitution and by-laws approved.**
5. **Brochure, conclusively proving that preventive medical procedures—by the early treatment of tuberculosis, syphilis, etc.—will save money in the long run by cutting down long-time institutional care, authorized for publication and distribution to township, city, county, and state officials.**
6. **Reports of twenty-one committees show amazing activity in behalf of better medical care and its distribution in Michigan.**
7. **Survey of Medical Relief cases by M.S.M.S Committee on Distribution of Medical Care authorized.**
8. **All county medical societies are urged to continue their filter systems and work in connection with the Afflicted Child Law.**

First Session of the Council

1. *Roll Call.*—The Mid-winter Meeting of The Council was called to order in the Judge Woodward Room of the Statler Hotel, Detroit, at 10:20 a.m. All Councilors were present except Dr. W. A. Manthei, who telegraphed he was unable to attend. Also present were Drs. Henry Cook, Henry A. Luce, L. Fernald Foster, Wm. A. Hyland, J. H. Dempster, Wm. J. Stapleton, Jr., J. M. Robb, G. C. Penberthy, Executive Secretary Wm. J. Burns, and Lynn Leet of the Executive Office.

2. *Minutes.*—The minutes of the meeting of December 12 were presented, read and approved.

3. *Secretary's Annual Report.*—Presented by Secretary L. Fernald Foster as follows:

SECRETARY'S ANNUAL REPORT—1937

I herewith submit the report of the Secretary for 1937.

The year 1937 marked another twelve months of constructive activity by the Michigan State Medical Society, in the interests of the medical profession and the people of this state. The Society continued the ambitious program laid out in former years, and blazed new trails in scientific, sociologic, and political areas.

Membership

The total membership for 1937 was 3,963 with dues of $38,953.50 accruing to the Society. The number of unpaid dues in 1937 was 144. The membership tabulation for the years 1936 and 1937 showing net gains and losses, unpaid dues and deaths is as follows:

1936	1937	Gain	Unpaid	Deaths
3,725	3,963	238	144	38

Of approximately fifty-five hundred physicians in Michigan, it is estimated that the maximum potential membership of the Michigan State Medical Society could be 4,725. This represents physicians in the active practice of medicine. Therefore, there are at most no more than 700 physicians in Michigan now eligible for membership in the Michigan State Medical Society.

In 1937 an appreciation of the benefits of membership, due to increased activities of the State Society, interested 238 additional physicians to affiliate with organized medicine. With the appointment of the new Membership Committee, and the augmenting of advantages of membership in the Society, I would estimate that the Michigan State Medical Society membership in 1938 should be 4,300.

MEMBERSHIP RECORD

	1936	1937	Loss	Gain	Unpaid	Deaths
Allegan		22	–	22	3	–
Alpena-Alcona-Presque Isle	13	18	–	5	–	–
Barry	15	15	–	–	1	–
Bay-Arenac-Iosco-Gladwin	69	71	–	2	2	1
Berrien	51	45	6	–	8	2
Branch	22	23	–	1	–	–
Calhoun	118	119	–	1	2	1
Cass	12	16	–	4	–	–
Chippewa-Mackinac	20	23	–	3	2	–
Clinton	11	11	–	–	–	–
Delta	18	20	–	2	1	–
Dickinson-Iron	21	23	–	2	1	1
Eaton	27	29	–	2	–	3
Genesee	153	155	–	2	7	–
Gogebic	27	26	1	–	–	–
Grand Traverse-Leelanau-Benzie	31	33	–	2	1	1
Gratiot-Isabella-Clare	33	35	–	2	1	–
Hillsdale	27	26	1	–	2	–
Houghton-Baraga-Keweenaw	34	38	–	4	1	–
Huron-Sanilac	25	29	–	4	1	–
Ingham	128	134	–	6	–	–
Ionia-Montcalm	33	38	–	5	–	–
Jackson	86	91	–	5	–	–
Kalamazoo-VanBuren	134	126	8	–	2	2
Kent	220	227	–	7	11	3
Lapeer	13	16	–	3	–	–
Lenawee	41	40	1	–	–	1
Livingston	17	19	–	2	–	1
Luce	12	13	–	1	–	–
Macomb	34	39	–	5	1	–
Manistee	14	16	–	2	–	–
Marquette-Alger	35	35	–	–	–	1
Mason	7	10	–	3	–	–
Mecosta-Osceola	19	17	2	–	1	1
Menominee	12	17	–	5	–	1
Midland	12	11	1	–	3	–
Monroe	36	37	–	1	2	1
Muskegon	70	77	–	7	–	1
Newago	10	10	–	–	–	1
Northern Michigan (Antrim, Charlevoix, Emmet, Cheboygan)	28	31	–	3	–	–
Oakland	114	125	–	11	5	1
Oceana	10	10	–	–	–	–
O.M.C.O.R.O. (Otsego, Crawford, Oscoda, Montmorency, Roscommon, Ogemaw)	13	14	–	1	1	–
Ontonagon	5	6	–	1	–	–
Ottawa	37	33	4	–	–	–
Saginaw	90	96	–	6	2	1
Schoolcraft	6	7	–	1	–	–
Shiawassee	29	33	–	4	–	1

St. Clair	42	47	–	5	–	–
St. Joseph	12	15	–	3	–	1
Tuscola	31	32	–	1	–	1
Washtenaw	159	149	10	–	15	2
Wayne	1,471	1,592	–	121	65	9
Wexford	18	23	–	5	3	–
Kalkaska, Missaukee						
	3,725	3,963	34	272	144	38
		3,725		34		
		238		238		

Deaths During 1937

During 1937 we regretfully record the deaths of the following members:

Bay County—Dr. Wm. G. Kelly, Bay City.

Berrien County—Dr. Ernest W. Tonkin, Niles; Dr. Robert H. Snowden, Buchanan.

Calhoun County—Dr. E. E. Hancock, Battle Creek.

Dickinson-Iron County—Dr. Arthur Lempton Haight, Crystal Falls.

Eaton County—Dr. W. L. McCormick, Bellevue; Dr. E. A. Schilz, Grand Ledge; Dr. E. A. Runyan, Linden.

Grand Traverse-Leelanau-Benzie—Dr. A. S. Rowley (retired), Traverse City.

Kalamazoo County—Dr. A. W. Crane, Kalamazoo; Dr. J. W. Hawkey (Emeritus Member), Bloomingdale.

Kent County—Dr. Collins H. Johnston, Grand Rapids; Dr. Thos. O. Menees, Grand Rapids; Dr. Fred H. Shorts, Kent City.

Lenawee County—Dr. Clarence H. Westgate, Morenci.

Livingston County—Dr. C. L. Sigler, Pinckney.

Marquette-Alger County—Dr. H. B. Markham, Marquette.

Mecosta County—Dr. John L. Burkart, Big Rapids.

Menominee County—Dr. J. K. Parish, Hermansville.

Monroe County—Dr. H. T. Gray, Carleton.

Muskegon County—Dr. Paul A. Quick (Honorary Member), Muskegon.

Newago County—Dr. P. Drummond, Grant.

Oakland County—Dr. Aileen B. Corbit, Oxford.

Saginaw County—Dr. W. F. Morse, Saginaw.

St. Joseph County—Dr. O. S. Behrentz, Three Rivers.

Shiawassee County—Dr. Philip E. Marsh, Bancroft.

Tuscola County—Dr. J. T. Redwine, Wahjamega.

Washtenaw County—Dr. Helene Schultz, Ann Arbor; Dr. C. O. Woodbridge, Saline.

Wayne County—Dr. Carl Bonning (Honorary Member), Detroit; Dr. Frederick B. Burke, Detroit; Dr. John L. Chester, Detroit; Dr. F. R. Olney, Detroit; Dr. Geo E. Potter, Detroit; Dr. Martin J. Schwanz, Detroit; Dr. Robert F. Shinsky, Detroit; Dr. Alois Thuner (Emeritus Member), Point Loma, California; Dr. Albert B. Walker, Detroit.

Financial Status

The fiscal year closed on December 24, 1937, and the statement of our certified public accountants, Ernst & Ernst (to be published in THE JOURNAL) shows the financial status as of that date. The following facts are noted:

1. The assets of the Society are $32,282.00 as against those of $40,345.00 in 1936. The net worth is shown as $11,764.00, a reduction from $19,738.00 a year ago.

The net loss incurred on the exchange of securities is $2,457.00, $2,218.93 of which is shown in the Medical Defense Fund. It would seem as though the present fixed assets of the Society indicate a better condition than before the exchanges were made, since the decrease in values was less than on the old assets.

2. The Medical Defense Fund shows a balance of $12,048.60, this being a decrease of $3,936.24. About 50% of this loss is represented by expenses over and above the funds allotted from the dues for Medical Defense purposes, the other 50% being sustained by the exchange of securities.
3. THE JOURNAL advertising sales in 1937 totaled $9,548.11, practically the same as in 1936. The cost of printing THE JOURNAL in 1937 was $9,965.04, as against $9,593.73, this slight increase being due largely to the increased material costs. The net income of THE JOURNAL in 1937 was $1,206.85, this however includes the allocation of funds for subscriptions from dues, this allocation amounting to $5,842.93.
4. The report shows no balance in the funds of the Joint Committee on Health Education, whose bookkeeping the Society has been doing. Before the audit of the books the balance in this fund was turned over to the Joint Committee.

With the exchange of securities and an increase in dues in 1938 the financial structure will be in good shape. During the past year there was a decided increase in the activities of the Society and the financial statement would seem to be consistent with this activity.

The 1937 Annual Meeting

Long-time members of the M.S.M.S., who have attended annual meetings for years, have advised me that the Grand Rapids Convention and Exhibition was the most remarkable and the best session in the history of the Michigan State Medical Society. The physician registration was 1,138. The program was developed to gain the interest and for the good of the general practitioner, who comprised the bulk of the registration. The general assembly type of program gave an opportunity to each registrant to hear all speakers, which in the aggregate provided a well-rounded Postgraduate Course. The doctors accorded the exhibitors generous attention and thereby created much goodwill for the benefit of the M.S.M.S. This was reflected in a substantial profit from the convention, despite the high cost of a greatly-augmented program with twenty-nine out-of-state speakers, and many extraordinary activities.

County Secretaries' Conferences

Two County Secretaries' Conferences were held since the Mid-winter Meeting of the Council in January, 1937, one on February 7th in Lansing, and another on September 29th in Grand Rapids. The first Conference attracted 101, including 40 secretaries. The registration at the Conference held in conjunction with the Annual Meeting of the M.S.M.S. totaled 84, including 34 secretaries. The 1938 Annual Conference is scheduled for Lansing on Sunday, January 23rd. I anticipate that all attendance records will be broken, due to the excellence of the program and even greater interest in the State Society.

Committees

The constantly expanding scientific, sociologic and economic importance of the medical practitioner is directly reflected in the work of his State Medical Society, which now requires twenty-five committees to aid physicians in their modern practice of medicine.

The scientific activities and accomplishments of the following committees are well known: Cancer Committee, Preventive Medicine Committee, Postgraduate Medical Education Committee, Maternal Health Committee, Mental Hygiene Committee, Occupational Disease Committee, Syphilis Control and Tuberculosis Control Committees, Radio Committee, Joint Committee on Health Education; the plans and programs of the sociologic groups have materially aided the medical profession and the public with the proper distribution of medical care in Michigan: the Committee on Distribution of Medical Care, Public Relations, Committee, Contact Committee to Governmental Agencies, Legislative Committee, Ethics Committee, Advisory Committee to Parole Commission, Committee on Health League, and Liaison Committees with the Hospital Association and with the State Bar of Michigan.

Society Activity

In the past year, your two Secretaries have visited forty-four of the fifty-four component county medical societies, usually accompanied by members of the Council or officiers or committee-men. We be-

lieve that the esprit de corps of the component societies is of the highest calibre at the present time. In addition, we note that county medical societies are following the suggestion of reëlecting efficient secretaries, replacements being made this year in only six or seven units.

The Radio Committee has continued its progressive program of public education by weekly broadcasts for a period of twenty-four weeks (from November 1 to April 11) over ten Michigan stations. Much credit and thanks are due the Joint Committee on Health Education for its help and coöperation in this work, particularly to its field Secretary, Dr. Clare Gates.

The Speakers' Bureau of the Society provided 46 speakers for medical societies, upon request. In addition, it despatched twenty-four speakers to address lay groups in various parts of the State. This is a total of 70 speakers for the first year of the Bureau's operation.

The "Placement Service" of the Michigan State Medical Society was created in 1937, to help any Michigan community which may feel the need of a doctor of medicine, and also to assist young physicians about to enter practice, or older doctors, to find locations.

During the year fourteen Secretary's Letters were issued, nine to Secretaries of county medical societies and five to all members of the M.S.M.S. In addition numerous legislative bulletins were sent to the membership and to the secretaries of the societies.

It is interesting to note that 12 component societies are now publishing their own Bulletins.

Recommendations

Your secretary concludes his report with the following recommendations, that:

1. A concerted membership drive be instituted during the months of February, March and April, 1938, and during the same period in subsequent years.

2. The ratio of reading matter and of advertising in THE JOURNAL approximate as closely as possible the 60%-40% basis.

3. In view of several requests for changes in Councilor and County Society districts, a study be made immediately of this important subject.

4. A definite program of press relations on the part of component county medical societies with their local press be instituted in all communities, in accordance with the State Society's plans and program.

5. The present type of Annual Meeting program —use of the General Assembly be maintained.

6. In the interest of economy, that the Public Relations Committee letters be made a part of the monthly Secretary's Letter.

Your Secretary wishes to take this opportunity to express his appreciation to this COUNCIL for its coöperation during the past year. It is a genuine pleasure to recognize the splendid interest and effort shown by all the Officers and Committes of the Michigan State Medical Society in their work. Too much commendation cannot be accorded Executive Secretary Burns and his office personnel for their untiring efforts in the interests of organized medicine. Mr. Burns has given unstintingly of himself in enthusiasm, constructive suggestions and coöperative effort at all times. He has been a real inspiration and aid to the Secretary in the discharge of his duties.

Respectfully submitted,

L. FERNALD FOSTER, M.D.,
Secretary

January 12, 1938.

The report was referred to the County Societies Committee.

4. *Treasurer's Annual Report.*—Presented by Treasurer Wm. A. Hyland as follows:

TREASURER'S REPORT—1937

As Treasurer of the Michigan State Medical Society, I wish to submit the following report for the year 1937.

As required by the by-laws of the Society, the usual indemnity bond was filed with the State Secretary.

The $2,000 American Telephone and Telegraph Co. bonds, 5s, due 1960, which were called on January 1st, 1937 and as per authority set forth at the Meeting of the Executive Committee on November 11th, 1936, I obtained $2,000 American Telephone and Telegraph 3¼ bonds due December 1st, 1966, for which I held Temporary Debentures without coupons at the time of the last Annual Treasurer's Report—January, 1937. These bonds were delivered to me in May, 1937.

The Executive Committee of the Council of the Michigan State Medical Society at its meeting of April 22nd, 1937, approved the motion that the Special Committee to Study Bonds (composed of Drs. Hyland, H. R. Carstens and V. M. Moore) be granted power to use its best judgment to dispose of the bonds of the Michigan State Medical Society as the committee sees fit, including all bonds not having an AAA rating.

As per the above authority, the following sales and purchases were executed during the past year.

Bonds Purchased

$7,500	U. S. Savings Bonds.....	7/ 1/47	75
1,000	Standard Oil Co. of New Jersey 3%	6/ 1/61	98
2,000	Consumers Power Co.....3¼%	11/ 1/66	100¼
2,000	Commercial Investment Trust3½%	7/ 1/51	102⅛
1,000	Dominion of Canada 3%	1/15/67	93¾
2,000	Detroit Edison Company....3½%	9/ 1/66	108⅝

Bonds Sold

$2,000	Community Power and Light5%	3/1/57	73¾
3,000	Public Gas and Coke.....5	12/1/52	42¼
5,000	G. R. Affiliated Corp.....5	10/1/55	75
2,000	50 Lower Broadway Bldg.....3	3/1/46	52
2,000	International Tel. & Tel.....5	2/1/55	72
2,000	Herald Square Bldg.....Inc.	5/1/48	47½
2,000	Peoples Light and Power....5½	7/1/41	
2,000	American Tel. and Tel.....5	2/1/65 Called	110

The following securities are now in my holding:

General Fund

Bonds

American Telephone & Telegraph Company 3¼%	$ 2,000.00
Associated Gas & Electric Corp. 4% inc.	2,000.00
Central Illinois Public Service Co.....4½	2,000.00
Commercial Investment Trust Corp...3½	2,000.00
Consumers Power Company.....3¼	2,000.00
Grand Rapids Affiliated Corporation..5	1,000.00
National Electric Power Company....5	5,000.00
New England Gas & Electric Co.....5	1,000.00
Standard Oil Company—New Jersey..3	1,000.00
United Light & Power Company....5½	2,000.00
United States of America Savings Bonds	4,000.00
	$24,000.00

Medico-Legal Defense Fund

Bonds

The Government of the Dominion of Canada 2½%	$ 1,000.00
The Government of the Dominion of Canada 3	1,000.00
Canadian Pacific Railway Co.....4	2,000.00
Detroit Edison Company.....3½	2,000.00
Grand Rapids Affiliated Corp.....5	1,000.00
New England Gas & Electric Company 5	1,000.00
New York Central Railroad Co.....4	2,000.00
Southern Pacific Company.....4½	2,000.00
United States of America Savings Bonds	3,500.00

Stock

National Gas & Electric Corporation—common—96 shares	960.00

According to Ernst and Ernst, Auditors, our bonds were quoted at the time of their rating at $28,978.00 valuation—that is, our present holdings. The valuation of our holdings of a year ago at this time would be $25,000.00. In addition to the much better security, our present holdings have a valuation of over $4,000.00 over our former list.

We have two holdings which are at present going through the process of re-organization under the bankruptcy act—namely, Associated Gas and Electric and National Electric Power Co. The holdings of the former being $2,000 and $5,000 in the National Electric Power Co.

Another holding, New England Gas and Electric, which totals $2,000 is not classified by the First National Bank of Chicago—Bond Department or the Bond Department of the Manufacturer's Trust Co. as the type of security that should be on our list. However, although it is quoted at 56 by the auditors, there is no market for this bond at present, but we have kept a close scrutiny of the sales and I believe that disposal as soon as possible would be wise.

We have $2,000 of the G. R. Affiliated Corp. remaining, having disposed of $5,000 at 75—a much better figure than we expected to receive. This is a very closely owned corporation and there is very little call for these bonds. However, within the last few days I have been connected with a source from which I may receive a definite offer, though somewhat under the figure of 75.

In conclusion, at present I think our holdings are of the highest type of safety with a fair income. Although many of the bonds we disposed of were of the highest type when purchased, they became through the passage of time and economic disturbance of a rather inferior grade and I think the plan of disposing of them during the past year was very timely and greatly insured our safety.

I appreciate very much the advice and help of the Council and the many friends of the Michigan State Medical Society, particularly the Bond Departments of the First National Bank of Chicago and the Manufacturer's Trust Co. of New York as also the Grand Rapids Trust Co.

Respectfully submitted,

WILLIAM A. HYLAND,
Treasurer.

* * *

The report was referred to the Finance Committee.

5. *Editor's Annual Report.*—Presented by Editor James H. Dempster as follows:

THE EDITOR'S ANNUAL REPORT—1937

The editor's report this year marks a period of ten years as editor of this JOURNAL. It has been ten years of exacting but very interesting work. The associations during the past decade have been of great interest and importance to me. The men who have been elected to control the destiny of the Michigan State Medical Society during this time have shown an earnest zeal to work in the interests of the society as they conceived their duty. During the latter years of this decade, many problems have arisen for solution which were unknown in 1927 and 1928. It has been ten years of valuable friendships as well as a liberal education for myself. During this time, THE JOURNAL has grown so that the last volume (36, 1937) is the largest ever published by the Michigan State Medical Society. The object of the Council has been to make THE JOURNAL reflect in a very real sense each year the spirit and accomplishments of the society.

Under the department, County Society Activities, every member has had the opportunity to follow from month to month the deliberations of the Executive Committee of the Council and twice a year the deliberations of the Council as a whole, and in November of each year a complete verbatim report of the deliberations of the governing body of the society, namely, the House of Delegates. Editorially, an attempt has been made to discuss the current movements in as fair and impartial a way as the editor is capable. We have sought a long range rather than an immediate view. An endeavor has been made to edit carefully all contributions. Sometimes it has been necessary to carry on correspondence with the author over some phases of this paper so that the finished JOURNAL does not by any means represent the entire duties of the editor. The Publications Committee have been consulted and the editor has endeavored to carry out faithfully the policy as agreed upon by the Publications Committee as representing the council. As large as THE JOURNAL has become, there is still a pressing demand for space. Many of the articles are long, almost entitled to be considered as monographs on the subjects discussed, and quite frequently letters are received from distant cities and towns in the United States for copies of our JOURNAL containing certain articles. This happens almost every week of the year.

The Woman's Auxiliary of the Michigan State Medical Society is very active and has been accorded ample space for their county society and other reports in THE JOURNAL. We feel that this is a forward step inasmuch as it brings the doctor's wife into close harmony with her husband's problems.

We have endeavored to include all medical news of general interest to all members of the society. This is of course an ideal that can be attained only through the coöperation of every member, whose help is asked to make THE JOURNAL as newsy and as interesting as possible.

All of which is respectfully submitted,

J. H. DEMPSTER.

* * *

The report was referred to the Publications Committee.

6. *Annual Report of the Publications Committee*—This report was presented by Dr. A. S. Brunk, Chairman:

REPORT OF PUBLICATIONS COMMITTEE

You have heard the report of the editor to the effect that the last volume, that is, volume 36 for the year 1937, is the largest yet gotten out by the society. The exact number of pages is 1,014 for the entire year. This number is increased by the fact that a number of columns of printed matter have been run through the advertising pages at the end of THE JOURNAL.

Your attention is called to the quality of THE JOURNAL, including the materials in the way of paper on which it is printed.

We believe it is generally conceded that THE JOURNAL is highly satisfactory as a publication. The articles are well displayed, the typographical arrangement is all that could be desired and the scientific papers, as well as other reading matter, are as free from typographical errors as it is possible to have them.

The editor calls our attention to the demand on the part of writers for space in THE JOURNAL. One object of your committee has been to give THE JOURNAL as wide an appeal as possible. By this, we mean only scientific papers, which have a wide appeal, are accepted rather than technical

papers, the space of which is in specialist journals.

As is well known, for many years a dollar and a half has been earmarked from each member's annual dues towards the publication of THE JOURNAL. This is the direct cost to each member of the society. He pays nothing more, though all must admit that THE JOURNAL is worth a great deal more, since it comes to each one's desk as a monthly postgraduate course. The major cost of publication is met through advertising. Mr. Burns has made a survey of the income from advertising and costs over a period of approximately three years—to be exact, thirty-four months. The average monthly income from advertising during this period was $767.63. The average cost of printing during this period was $898.85. If the publication of THE JOURNAL depended entirely on the advertising, it would be seen that the difference between these two sums indicates a loss. Efforts, however, have been made to cover this loss, by an increased advertising. These efforts have been partially successful, but owing to the increased costs of printing, particularly during the past year, the net receipts from advertising alone have not met the increased cost of publication.

Of course, added to the advertising is the dollar and a half per member which, on a basis of 3,500 members, a conservative estimate, the income from membership dues has been $5,250. This sum has taken care of the increased cost of publication so far, together with the editor's salary, and has left a margin to the good. According to Mr. Burns, "In a strict business sense, relying exclusively on the income from advertising, THE JOURNAL loses money each year and will continue to do so until we either secure more advertising or cut down on the number of pages devoted to reading matter." Of course, no lay publication depends entirely on advertising for its revenue. The annual subscription, which would correspond in our case to the dollar and a half per member, is a considerable sum towards defraying the expenses of publication; even the three cent daily price of the newspaper is a valuable contribution to the expense of the publication of newspapers. It is needless to say that your committee heartily endorses the efforts of the Executive Secretary to increase the amount of advertising in THE JOURNAL.

All of which is respectfully submitted.

A. S. BRUNK, M.D., *Chairman,*
ROY H. HOLMES, M.D.
T. F. HEAVENRICH, M.D.
F. T. ANDREWS, M.D.
J. E. MCINTYRE, M.D.

* * *

7. *Annual Report of Medico-Legal Committee.*—Presented by Dr. W. J. Stapleton, as follows:

REPORT OF THE MEDICO-LEGAL COMMITTEE—1937

Herein is the annual report of the Medico-Legal Committee of the Michigan State Medical Society for the year 1937.

Thanks are due the committee members for their coöperation. A special word of thanks is due the Chairman—Doctor Angus McLean—for his constant help in the work of the Committee. Our thanks are also due the attorneys for the Society—Messrs. Barbour and Purdy. They are at all times ready to aid in answering legal questions. A word of thanks goes to Doctor W. C. Woodward of the A.M.A. Medico-Legal Bureau for his help in several cases. And to William J. Burns, the Executive Secretary, our thanks for much coöperation.

The Committee has developed into a sort of information bureau for other things that are not just medico-legal. We do our best to answer all questions. Of course, most of the work is in answering inquiries and in consultation with doctors who have problems along medico-legal lines. Sometimes it is just a question to be answered over the telephone. Other cases require consultation with the doctor. Here is where Doctor McLean so often comes into the picture. The three of us get together and discuss the matter. Many letters are answered from out of town doctors who write in. It has never been thought necessary to keep an exact record of these cases unless it is unique.

The Committee is pleased to have received during the year several letters of appreciation for the work of our attorneys and the Committee. As much of the matter discussed is confidential in character, our report does not give complete details.

Respectfully submitted,
ANGUS MCLEAN, M.D.,
Chairman,
I. W. GREENE, M.D.
D. W. HART, M.D.
WM. R. TORGERSON, M.D.
WM. J. STAPLETON, JR., M.D.

* * *

The report was referred to the County Societies Committee.

8. *Report of Councilors.*—Dr. Greene as Chairman of the County Societies Committee presented the tabulated reports of Councilors on the condition of the profession in their districts. This was augmented by verbal reports of the individual councilors. Dr. Greene's summation was (a) Where a county society has a general fund or treasury surplus, there seems to be greater enthusiasm, larger membership and better attendance; (b) social activities, such as dinner meetings and at least one annual party, seem to help esprit de corps.

* * *

Reports referred to the County Societies Committee.

The First Session recessed at 12:30 P. M.

Second Session of the Council

The Second Session convened at 1:30 P. M.

9. *Committee on Scientific Work.*—Report was given by Secretary Foster on plans for the 1938 Annual Meeting. To conserve time at the first session of the House of Delegates, the matter of placing the A.M.A. Delegates' report in the Handbook for M.S.M.S. Delegates was discussed. Motion of Dr. Riley seconded by several that the A.M.A. Delegates be requested to prepare their report for publishing in the Handbook. Carried unanimously.

The Secretary reported that the technical exhibit of seventy-six spaces was practically sold out.

10. *Reports of other Committees.*—Drs. L. W. Shaffer, R. H. Pino, P. A. Klebba, O. A. Brines, B. R. Corbus, and M. H. Hoffmann entered the meeting.

The various committee chairmen reported for their committees, as follows:

(a) Dr. Luce for Mental Hygiene Committee. Referred to County Societies Committee.

(b) Dr. Foster for Public Relations Committee. Referred to County Societies Committee.

(c) Dr. Riley for Advisory Committee to Parole Commission. Referred to County Societies Committee.

(d) Dr. Cook for Nurses Training School Committee. (No action taken.)

(e) Dr. Miner for Iodized Salt Committee. Referred to Finance Committee.

(f) Dr. Porter for Ethics Committee. Referred to County Societies Committee.

(g) Dr. Tuck for Michigan Health League. Referred to County Societies Committee.

(h) Dr. Cole for Radio Committee. Referred to County Societies Committee.

(i) Dr. Corbus for Joint Committee on Health Education. Referred to County Societies and Finance.

(j) Dr. Campbell for Maternal Health Committee. Referred to County Societies and Finance.

(k) Dr. Brines for Cancer Committee. Referred to Finance Committee.

(l) Dr. Collisi for Advisory Committee to Woman's Auxiliary. Referred to Finance and County Societies.

(m) Dr. Gruber for Liaison with Hospitals. Referred to County Societies Committee.

(n) Dr. Denham for Liaison with State Bar. Referred to County Societies Committee.

(o) Dr. Klebba for Advisory Committee on Occupational Diseases. Referred to County Societies Committee.

Motion of Dr. Holmes-Greene that portions of the Krogstad Conference on Occupational Diseases be published in the M.S.M.S. JOURNAL. Carried unanimously.

(p) Dr. Pino for the Committee on Distribution of Medical Care. Referred to County Societies Committee and Finance Committee.

11. *Bills Payable.*—Bills payable for the month were presented, studied, and on motion of Drs. Carstens-McIntyre ordered paid.

12. *Basic Science Board.*—The Executive Secretary reported on the status of these appointments.

13. *Physician at Football Games.*—The correspondence urging the necessity of a doctor of medicine at all football games was read and discussed. Motion of Drs. Cummings-Andrews that the matter be referred to the Michigan School Health Association. Carried unanimously.

14. *Uniform Narcotic Drug Act.*—A letter from Dr. Wm. M. Donald suggesting that the act be tested for its constitutionality was read and discussed. Motion of Drs. Cummings-McIntyre that the matter be referred to the M.S.M.S. Legislative Committee for further study, and report to the Executive Committee at a later date. Carried unanimously.

The Second Session was recessed at 5:20 P. M.

Third Session of the Council

The Third Session was convened at 7:30 P. M.

15. *Proposed Change in Constitution.*—The suggestion that a recommendation be made to the House of Delegates to change Article Three, Section One, so that active membership in a county medical society shall include active membership in the State Society, was discussed. Motion of Drs. Haughey-Brunk that the matter be studied by a committee to be appointed by the Chair. Carried unanimously.

16. *Additional Committee Reports.*—(a) Dr. Hoffmann reported for the Membership Committee. Referred to the County Societies Committee.

(b) Dr. J. D. Bruce presented the report of the Committee on Postgraduate Medical Education, which was referred to the County Societies Committee and the Finance Committee.

REPORT OF COMMITTEE ON POST-GRADUATE MEDICAL EDUCATION

The Council has received the report on postgraduate activities for the year 1936-1937.

The total attendance of physicians on all courses for that period was 1,589, divided as follows:

Intensive Intramural Courses (Ann Arbor and Detroit)	354
Extramural Courses	1,107
Courses in the Upper Peninsula and in the upper part of the Lower Peninsula in Maternal and Child Welfare under Federal Aid through the State Department of Health	128
Total	1,589

In the extramural courses, 592 physicians attended from 50 to 100 per cent of the eight presentations.

The attendance from outside of the State has increased over previous years. Of the 354 physicians coming to Ann Arbor and Detroit, ninety-two, or 25 per cent, were from outside the State. Fourteen states and two Canadian provinces were represented. Ohio headed the list. Indiana, Ontario and New York were next, with smaller numbers from Wisconsin, Texas, Pennsylvania, Oklahoma, New Jersey, Massachusetts, Kentucky, Iowa, Illinois, California and Alabama.

On December 16, 1937, the Advisory Committee on Postgraduate Education met at the Wayne County Medical Building, Detroit. Besides the chairman, Dr. James D. Bruce, those present included Drs. A. P. Biddle, B. R. Corbus, H. H. Cummings, W. B. Fillinger, G. C. Penberthy, R. R. Smith, D. T. Sugar and C. C. Slemons; also Dr. P. R. Urmston, chairman of the Council; Dr. L. F. Foster, secretary; Wm. J. Burns, executive secretary; Dr. M. R. Kinde, of the W. K. Kellogg Foundation, and Dr. Hamilton H. Anderson, who was making a survey of postgraduate education for the American Medical Association

A report of attendance on the autumn extramural course for 1937 was made. This showed a decrease of approximately 13 per cent, as against an increase of 15 to 20 per cent each year over the past three years. Comparing the attendance records, it will be seen that the northern center of Traverse City-Cadillac-Manistee-Petoskey slightly exceeded the 1936 attendance. Battle Creek-Kalamazoo also showed some increase. The Bay City attendance was approximately the same, while Flint, Grand Rapids and Lansing-Jackson showed a decrease of, approximately, 20 per cent.

Dr. R. R. Smith reported that Councilor V. M. Moore, of Grand Rapids, feels that the physicians in his district would attend in larger numbers if the time of the meetings were changed to late afternoon and early evening, with a dinner between the two sessions.

The Committee felt that the hours for the meetings should be arranged between the different centers and the Postgraduate Committee.

Dr. W. R. Fillinger stated that the acoustics in one of the Grand Rapids hospitals were very poor. Dr. Smith volunteered to investigate this matter and report to the chairman.

The chairman raised the question of decreasing the number of teaching days from eight to seven or, possibly, six, and the establishment of a new center to serve particularly the countries of Lenawee, Monroe, Livingston, Jackson and Washtenaw. The latter might be done through a re-arrangement of the Jackson-Lansing center, making Lansing a single center and establishing a joint center between Jackson and Adrian; or, by continuing the Jackson-Lansing center, and establishing a new center at Ann Arbor, which would serve these counties equal-

ly well. This would have the added advantage of greater hospital, laboratory and clinical facilities. The Committee favored a re-arrangement but did not make a specific recommendation.

Various methods were suggested to assist the local councilors in the maintenance of interest in these courses and to help in making suitable local arrangements. It was thought that the appointment of two men might be helpful—the first, an older man, well established in the community; and the other, a younger man to whom many of the details might be assigned.

It was further suggested that, in addition to the notifications sent out well in advance of the course by the chairman of the Committee, each county secretary should send out notices to the membership in his district, these notices to be sent about a week before the beginning of the course and the expense of printing and mailing borne by the county societies. While these suggestions were endorsed by the Committtee, later in the discussion both Dr. Foster and Mr. Burns thought better results might be had by having these notices sent out from the central office at Lansing, under the conditions outlined for the county societies.

It was felt by the Committee that, in addition to the work of the Councilor and such aides as should be given him, each county society should assume a considerable measure of responsibility in furthering the postgraduate program of the Society.

The matter of certification for those physicians who have met the requirements of the extramural four-year period, or who have done comparable work, was discussed. The Committee approved the plan of presenting the certificates at an evening session during the annual meeting of the State Medical Society. This is in accord with former recommendations and approval of the House of Delegates in the 1937 session. It was agreed that a blank be given at the State meeting—the usual custom in larger groups—and that the certificates be sent to each county society for presentation at a regular meeting of the society.

It was also suggested that the Biddle lecture be given the same evening that the certificates are presented.

The chairman drew attention to the recommendation of the Council that the syllabus of lectures be given only to those who had attended 50 per cent or more of the four-year autumn course, or the Practitioner's Course given each year in Detroit over a like period.

Inasmuch as a number of men had attended the requisite number of lectures in former years, and this year's failure might have been unavoidable, the Committee decided to send the volume to some 450 physicians who had less than the requisite attendance record, with a statement for one dollar, requesting that the volume be returned if they did not wish to keep it. Approximately two hundred physicians sent checks or currency and about twenty volumes were returned, leaving about two hundred and thirty volumes that have not been returned or paid for. Mr. Burns volunteered to send an additional notice to those who have not yet responded. As there are many requests from those who have not had an opportunity to purchase these volumes, their return by those not interested in retaining them would be greatly appreciated.

Since the publication of the volume is an item of considerable expense, costing, including postage, about $1,000, the Committee advised that subscriptions at the cost price of the volume be taken at the autumn lectures, to be paid for upon delivery. This recommendation is to be subject to Council action.

A list of subjects for the course in 1938 was presented to the Committee, and was approved; also, the suggestion of the chairman of sending a quite complete preview of the presentations to the profession prior to the beginning of the course.

During the dinner hour there was a discussion of postgraduate education, with general agreement that it was one of the most important activities of the Society.

Dr. Foster and Mr. Burns volunteered to handle all news releases pertaining to our educational programs through the executive offices in Lansing.—(Report of Committee from notes taken by Dr. H. H. Cummings at the meeting on December 16, 1937.)

According to the custom in previous years, the Committee sent out a questionnaire to all registrants. The form has varied from year to year, but has always included a request for suggestions, criticisms, comments, and sometimes for specific information. This year's questionnaire was sent in the form of a return postal card, as follows:

December 28, 1937

Dear Doctor:

Every year we have received many comments and suggestions from the registrants of the postgraduate course, which have been very helpful in formulating new programs. We are trying constantly to make these programs as helpful as possible to our members. Would you be kind enough, on the return postal card, to give us what assistance you can in formulating the 1938 program?

With every good wish for a happy and successful New Year, we are,

Cordially yours,
Advisory Committee on Postgraduate Education

The return card, with questionnaire, was as follows:

ADVISORY COMMITTEE ON POSTGRADUATE EDUCATION

Ann Arbor, Michigan

1. Subjects suggested for 1938.
2. I favor the hours:
   (a) 9 a. m. to 1 p. m. ———
   (b) 1 p. m. to 5 p. m. ———
   (c) 4 p. m. to 8 or 9 p. m., including dinner at or near place of meeting. ———
   (d) The present hours of 10:30 a. m. to 2:30 p. m. ——
3. I favor a reduction from the present 8-day schedule to (a) 7 or (b) 6 days. (Underline one.)
4. Further comments.

(Signed)————————————

The card was sent to 904 of those in attendance on last autumn's course. Sixteen names appeared on the registration list for which addresses could not be found. About 400 replies have been received. Of these, approximately 350 have been tabulated, with the following results:

Question 1. Subjects suggested for 1938. One hundred and twenty-three physicians suggested subject matter for the 1938 autumn course. There were many helpful suggestions in this list which will be considered by the Committee before the program is finally decided upon.

Question 2 related to choice of hours for the presentations.

(a) 9 a.m. to 1 p.m.....87
(b) 1 p.m. to 5 p.m. .....56 — 17 = 39
(c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting.... 51
(d) The present hours of 10:30 a.m. to 2:30 p.m. 138

It will be noted in this connection that the 1:00-5:00 hours had already been chosen by the Traverse City-Cadillac-Manistee-Petoskey group, and their meetings held last year within those hours. The number replying from this area has been subtracted from the total of votes for the 1:00 to 5:00 p.m. hours, so not to prejudice the vote for this period.

The vote according to centers is as follows:

Traverse City-Cadillac-Manistee-Petoskey
(a) 9 a.m. to 1 p.m. 4
(b) 1 p.m. to 5 p.m. (present hours) 17
(c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 5
(d) The present hours of 10:30 a.m. to 2:30 p.m. 3
94 cards sent to Traverse City-Cadillac-Manistee-Petoskey center. 30 replies, or 30 per cent.

Grand Rapids
(a) 9 a.m. to 1 p.m. 14
(b) 1 p.m. to 5 p.m. 5
(c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 16
(d) The present hours of 10:30 a.m. to 2:30 p.m. 34
172 cards sent to Grand Rapids center. 73 replies, or approximately 40 per cent.

Lansing-Jackson
(a) 9 a.m. to 1 p.m. 17
(b) 1 p.m. to 5 p.m. 21
(c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 4
(d) The present hours of 10:30 a.m. to 2:30 p.m. 26
169 cards sent to Lansing-Jackson. 69 replies, or approximately 40 per cent.

Flint
(a) 9 a.m. to 1 p.m. 8
(b) 1 p.m. to 5 p.m. 5
(c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 4
(d) The present hours of 10:30 a.m. to 2:30 p.m. 13
132 cards sent to Flint. 32 replies, or approximately 25 per cent.

Battle Creek-Kalamazoo
(a) 9 a.m. to 1 p.m. 28
(b) 1 p.m. to 5 p.m. 1
(c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 10
(d) The present hours of 10:30 a.m. to 2:30 p.m. 32
179 cards sent to Battle Creek-Kalamazoo. 71 replies, or approximately 40 per cent.

Bay City
(a) 9 a.m. to 1 p.m. 21
(b) 1 p.m. to 5 p.m. 2
(c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 5
(d) The present hours of 10:30 a.m. to 2:30 p.m. 33
153 cards sent to Bay City. 61 replies, or approximately 40 per cent.

Question 3. Choice of present 8-day schedule, or a reduction to (a) 7, or (b) 6 days.

The replies to this question were as follows: Practically all were in favor of the eight-day schedule. Eleven favored a reduction to seven or six days, while several asked that the number of days be increased.

Question 4. Further comments. There were a few criticisms of the manner of presentations. Still more urged that the meetings begin promptly on time. Approximately 70 per cent had nothing but praise for the work, and all urged its continuance. It is interesting and extremely gratifying to receive 136 excellent suggestions. Of the criticisms, all were constructive, and approval of the general plan of the extramural program was unanimous.

Mr. Burns has asked that request for funds be made to support the postgraduate program. If a seventh center is established, there will be an added expense of, approximately, $400, and if the needs of the Upper Peninsula and the northeastern section of the State are to be met with reasonable adequacy, there will be an estimated increase of, at least, another $400. On the basis of last year's contribution, this would mean setting aside $2,300. This is based on the assumption that the autumn course and the practitioners' course of one week in May, in Detroit, will not be subject to a fee, and that the published résumé of presentations will be supplied at cost to those desiring to keep the proceedings up to date. It is suggested that this amount be considered.

It is now twelve years this month since the Council invited the faculties of our two medical schools to meet with it for a discussion of ways and means to provide for the postgraduate needs of the Michigan profession. The progress of this movement during the intervening years has been so significant as to mark the year 1926 as a milestone in the medical history of Michigan. Increasing interest is shown all over the country, as evidenced by the meeting during the 1937 session of the American Medical Association of accredited representatives from over half of the state medical societies, and their determination to go forward in a united effort to ascertain how increasing postgraduate needs might best be met. This action was coincident with the appointment by the Council on Medical Education of the American Medical Association of a commission which proposes a three-year study of all post-collegiate medical educational activities and needs. The early recognition by the Council of the Michigan State Medical Society of the obligation to provide for the continuing education of our profession may be viewed with justifiable pride.

The interest shown by many groups of our citizens and by government itself in medical care and the alleged disastrous results of governmentally controlled medical services in many foreign countries place a great responsibility upon the American profession. As doctors are individualists to a notable degree, undoubtedly opinions will differ widely as to the importance of these problems and how they best be met. While the questions of distribution of service and payment therefor are important issues that must be met, the outstanding problems undoubtedly concern the quality of medical service.

Adequate professional preparedness through continuing education and information to the public as to what constitutes good medical service, as well as how the health needs of the people had best be met, are the present objectives of the program in Postgraduate Medicine and that of the Joint Committee on Health Education. These interests and objectives, serving importantly in protecting the public and in perpetuating medical ideals, should be accorded continuous support.

* * *

General discussion of Michigan's postgraduate medical education ensued, with each Councilor presenting his suggestions and criticisms as gleaned from physicians in his district. Dr. Bruce felt that the future of medicine depends upon the quality of medical service given by the average practitioner of medicine; that postgraduate medical education is raising the quality of practice, and that the public is being educated in medical matters to an amazing degree.

The Third Session was recessed at 9:50 P. M.

Fourth Session of the Council

The Fourth Session convened at 9:15 A. M.

17. *Reference Report of Committee on County Societies.*—Dr. Greene presented the report of his committee, covering seventeen points which were discussed individually and approved item by item.

REFERENCE REPORT OF COMMITTEE ON COUNTY SOCIETIES

1. *Secretary's Report.*—The general report was approved and all recommendations are concurred in except No. 1, which we would advise should read, "A concerted membership drive be instituted during the months of February, March and April, 1938, and during the same period during subsequent years as far as it is in accord with the recommendations of the Membership Committee of the State Society; and it is further suggested that the recom-

mendations of the Public Relations Committee be captioned separately in the Secretary's Letter so that it will be understod that this committee is functioning.

2. *Membership Committee.*—We approve of Dr. Hoffmann's report and recommend that the ideas brought forth in his report be presented to the Secretaries at the Annual Conference on January 23, 1938.

3. *Medico-Legal Committee.*—We fully endorse and approve the report of the Medico-Legal Committee.

4. *Advisory Committee on Syphilis Control.*—Committee report approved as far as submitted.

5. *Radio Committee.*—We approve of the report and wish to thank the committee for its work and suggest that the coöperating radio stations be given a letter of thanks by the State Society.

6. *Maternal Health Committee.*—We recommend the report be approved but suggest that efforts along the line of lay education be carefully studied and that the major emphasis be put upon the education of the physician.

7. *Mental Hygiene Committee.*—We approve the report and further recommend that talks given along the line of mental hygiene and allied subjects, be not too technical in their language and so presented as to be of aid to the general practitioner in coping with these problems.

8. *Advisory Committee to Parole Commission.*—Approve and recommend that the contact be continued.

9. *Ethics Committee.*—We approve the report.

10. *Advisory Committee to the Woman's Auxiliary.*—We approve the report.

11. *Liaison Committee with State Bar of Michigan*—We approve and recommend that the Executive Committee formulate such policies as are necessary in guiding this committee.

12. *Liaison Committee with State Hospital Association.*—We approve the report.

13. *Committee on Health League.*—We approve the report.

14. *Advisory Committee on Occupational Diseases.*—We approve action up to date and recommend further study.

15. *Joint Committee on Health Education.*—We approve the report.

16. *Committee on Distribution of Medical Care.*—We accept the report and approve the questionnaire, but advise the questionnaire be abbreviated, edited, and distributed to the Secretaries on the occasion of their annual conference in Lansing, January 23.

17. *Reports of Councilors.*—We believe that the various councilors have covered their districts very well and that they have been in good contact with their county societies and we approve their activities and advise semi-annual reports be made in future, with questionnaires being mailed out well in advance of general council meetings.

Motion of Dr. Greene, seconded by several, that the report as a whole be adopted. Carried unanimously.

18. *Reference Report of Publications Committee.*—Dr. Brunk presented the report of his committee, covering nine points which were discussed individually and approved item by item.

REFERENCE REPORT OF PUBLICATIONS COMMITTEE

1. Your Publications Committee met on January 12 and discussed the following matters, some of which were referred to it by The Council:

(a) Size of Journal. Motion of Drs. Holmes-McIntyre that the Publications Committee respectfully recommend to The Council that THE JOURNAL be limited to approximately 100 pages per issue, in the interests of economy. Carried.

(b) County Society News. Motion of Drs. Andrews-Heavenrich that the Editor be instructed to limit the county society news reports to a maximum of ten lines each month, per society, except under extraordinary circumstances, and that the Secretary be instructed to present this matter at the County Secretaries' Conference on January 23.

Also that the Woman's Auxiliary and the State Board of Health News each be submitted to the Editor each month and be allotted not more than 1½ pages per month. Carried.

(c) Distillery Advertising. Motion of Drs. McIntyre-Heavenrich that the Publications Committee respectfully recommend to The Council that THE JOURNAL may list high-grade distillery and brewery advertising in its pages. Carried unanimously.

(d) Editor's Report. Motion of Drs. Holmes-McIntyre that the report of the Editor, as submitted to The Council, be accepted. Carried unanimously.

(e) Mattson Pension. Motion of Drs. Heavenrich-McIntyre that this Committee report to The Council this problem, for an opinion, with the suggestion that the Secretaries secure an opinion at the A.M.A. in Chicago as to the status of the case and what other state medical societies are doing, and thereafter report to the Executive Committee. Carried.

(f) Professional Cards. Motion of Drs. Andrews-McIntyre that this Committee recommend to The Council that no action be taken. Carried unanimously.

(g) Journal Budget. The budget was studied and referred to the Budget Committee, with the recommendation that it take into consideration that there will be less advertising revenue and increased cost for printing, ink and paper during 1938.

(h) Advertising Solicitor. Motion of Drs. McIntyre-Heavenrich that the securing of additional advertising solicitors be recommended to The Council for approval. Carried unanimously.

(i) Report of Chairman of Publications Committee. This was read and approved, with the recommendation that it be presented to The Council with the above matters.

Motion of Drs. Andrews-McIntyre that the report as a whole be adopted. Carried unanimously.

19. *Additional Committee Reports.*—State Health Commissioner Don W. Gudakunst, and Drs. L. O. Geib, B. H. Douglas and L. W. Shaffer entered the meeting. Dr. Geib presented the report of the Preventive Medicine Committee; Dr. Douglas presented the report of the Advisory Committee on Tuberculosis Control; Dr. Shaffer presented the report of the Advisory Committee on Syphilis Control.

Commissioner Gudakunst was welcomed by The Council, and discussed the type of health service in this state together with needs for the future, including a medical coördinator of preventive medicine procedures.

Motion of Drs. Greene-Sherman that the report of the Advisory Committee on Tuberculosis Control be adopted, that the Public Relations Committee of the M.S.M.S. integrate the work of the Committee to the M.S.M.S. membership, and that the coöperation of the Governor's Coördinating

Committee be sought in this activity. Carried unanimously.

Motion of Drs. Greene-Cummings that the report of the Advisory Committee on Syphilis Control be adopted. Carried unanimously.

Motion of Drs. Greene-McIntyre that the report of the Preventive Medicine Committee be adopted. Carried unanimously.

These Committees are to advise Dr. Foster just what projects they wish the Public Relations Committee to integrate. Motion of Drs. Cummings-McIntyre that the Preventive Medicine Committee prepare statements and statistics which may be presented to supervisors in the various counties to prove that preventive procedures, by the early treatment of syphilis, tuberculosis, etc., will save money in the long run by cutting down long-time institutional care. Carried unanimously.

20. *Violations.*—Dr. McIntyre, Secretary of the State Board of Registration in Medicine, presented a coöperative arrangement with the State Department of Health to curb violations of the Medical Practice Act.

21. *Fees for Insurance Information.*—Dr. C. E. Umphrey, President of the Wayne County Medical Society, and Mr. James A. Bechtel, its Executive Secretary, entered the meeting to discuss the M.S.M.S. House of Delegates' resolutions of 1929 and 1937 re fees for insurance information. The matter was thoroughly discussed to the satisfaction of President Umphrey. Any problems may be clarified at the 1938 meeting of the M.S.M.S. House of Delegates.

22. *Medico-Legal Committee.*—The activity of the Medico-Legal Committee was thoroughly discussed, together with a study of the By-Laws governing this work. Motion of Drs. Andrews-McIntyre that all members of the present committee, except Dr. Hart, be reappointed, and that Dr. S. W. Donaldson be named to the vacancy. Carried unanimously. (Secretary Foster explained that Dr. Hart had another committee appointment which would keep him very busy.)

Motion of Drs. McIntyre-Moore that Dr. Angus McLean be elected as Chairman of the Medico-Legal Committee. Carried unanimously.

Motion of Drs. Carstens-Cummings that The Council vote no salary for the Chairman, but $1,000 for 1938 for the Secretary of the Medico-Legal Committee. Carried unanimously.

The Fourth Session was recessed at 12:30 P. M.

Fifth Session of the Council

The Fifth Session convened at 1:30 P. M.

23. *Afflicted-Crippled Child Laws.*—Dr. H. B. Fenech of the Crippled Children Commission, and Dr. E. R. Witwer of the Michigan Association of Roentgenologists, were present to discuss recent developments in connection with the afflicted-crippled child laws. The Council decided that representatives of the M.S.M.S. should be present at all meetings of the C.C.C. and of the Auditor General at which revision of the fee schedules, to be republished as of March 1, 1938, will be discussed. The matter will be studied by the x-ray group in February. Dr. Witwer stated that his group would undoubtedly request a revision of the original x-ray fee schedule, and also for a clearer understanding of arrangements re x-ray work. Commissioner Fenech stated that the Attorney General had ruled that the flat rate for hospitals is illegal.

24. *Newspaper Headlines.*—Dr. L. J. Hirschman was present and invited the attention of The Council to unfortunate newspaper headlines such as "Under the Knife." He recommended that the newspapers be requested to eliminate terrifying headlines, and to keep out of stories the names of hospitals wherein deaths from ordinary causes resulted.

President Cook will appoint a committee to contact the newspapers.

REFERENCE REPORT OF FINANCE COMMITTEE

25. *Reference Report of Finance Committee.*—Presented by Dr. H. R. Carstens. Dr. Carstens gave a résumé on the financial condition of the Society for 1937, based on the Auditor's report. He predicted a loss in JOURNAL advertising for 1938. Motion of Drs. Andrews-Holmes that the inventory item covering the "Medical History of Michigan" be stricken off the M.S.M.S. books as an asset. Carried unanimously. Motion of Dr. Holmes, seconded by several, that at the Secretaries' Conference of January 23, the Medical History of Michigan be distributed to the county society secretaries for libraries (local, public, medical, and hospital libraries). Carried unanimously.

Dr. Carstens presented the proposed budget for 1938, which was discussed item by item. Motion of Drs. Greene-Holmes that the Medico-Legal Fund be allotted $3,500 for 1938 expenses. Carried unanimously.

Motion of Drs. Holmes-Cummings that the amount for "Delegates to A.M.A." be set at $1,200, and that the Executive Committee decide, with what money is left from the delegates' expenses, what officers of the M.S.M.S. can be sent to the A.M.A. meeting. Carried unanimously.

Motion of Drs. Brunk-Haughey that the budget as presented by the Finance Committee Chairman be adopted. Carried unanimously. THE JOURNAL budget, as presented, was approved on motion of Drs. Carstens-Cummings. Carried unanimously.

SOCIETY BUDGET FOR 1938

INCOME	
4,100 members at $12 (less ½ and ¼ dues of any new members)	$ 48,200.00
Interest	900.00
Total income	$ 49,100.00
Less allotment to Medico-Legal Fund	3,500.00
Less allotment to THE JOURNAL	6,000.00
Total Net Income	$ 39,600.00
APPROPRIATIONS:	
Administrative and General:	
Medical Secretary Salary	2,400.00
Executive Office Salaries	9,960.00
Extra Office Help	100.00
Office Rent and Light	735.00
Printing, Stationery, Supplies	900.00
Postage	750.00
Insurance and Fidelity Bonds	185.00
Auditing	175.00
New Equipment	400.00
Telephone and Telegraph	400.00
Miscellaneous	150.00
Total Administrative and General	$ 16,155.00
Society Expenses:	
Council Expense	2,750.00
Delegates to A.M.A.	1,200.00
Secretaries Conferences	850.00
General Society Travel Expense	1,600.00
Secretary's Letters	350.00
Publications Expense	500.00
Reporting Annual Meeting	125.00
Education Expenses	500.00
Legal Expense	250.00
Sundry Society Expenses	550.00
Organizational Expense	3,500.00
Contingent Fund	4,370.00
Total Society Expense	$ 16,545.00
Less gain from Annual Meeting	750.00
Net Society Expense	$ 15,795.00

Committee Expenses:	
Legislative Committee	1,000.00
Committee on Distribution of Medical Care	200.00
Cancer Committee	650.00
Preventive Medicine Committee: (Including Adv. on Syphilis and Adv. on Tuberculosis Control.)	500.00
Radio Committee	25.00
Postgraduate Medical Education	2,000.00
Maternal Health Committee	250.00
Goitre (Iodized Salt Committee)	250.00
Public Relations Committee	700.00
Ethics Committee	100.00
Membership Committee	50.00
Repre. to Joint Com. on H. E.	1,000.00
Adv. to Woman's Auxiliary	50.00
Committee on Health League	150.00
Sundry Other Committees	325.00
Committee Reserve	400.00
Total Committee Expenses	$ 7,650.00
Grand Total	$ 39,600.00

BUDGET FOR "THE JOURNAL"—1938

INCOME:		
Subscriptions	$6,000.00	
Advertising	8,550.00	
Reprint sales	300.00	
Total Journal Income		$14,850.00
EXPENSES:		
Editor's Salary	$3,000.00	
Editor's Expense	600.00	
Printing and Mailing	9,550.00	
Discounts & Commissions	1,250.00	
Postage	300.00	
Reserve	150.00	
Total Journal Expenses		$14,850.00

26. *1939 Annual Meeting.*—Council Moore presented the invitation of the Kent County Medical Society requesting that the 1939 Annual Meeting of the M.S.M.S. be held in Grand Rapids. Dr. Moore was thanked and the invitation was referred to the House of Delegates.

27. *Permanent Delegates to A.M.A.*—The suggestion that the Secretary and President-Elect of the M.S.M.S. be made permanent delegates to the A.M.A. was referred to the House of Delegates.

28. *Councilors' Expenses.*—Motion of Drs. Holmes-Barstow that the M.S.M.S. pay all expenses of the councilors incurred in the course of their duties within their own districts and at all regular meetings of The Council and of the Executive Committee. No other expenses shall be paid unless previously authorized by the Chairman of The Council. Carried unanimously.

29. *Michigan Health League.*—Dr. Greene reported on the proposed Constitution and By-Laws of the Michigan Health League, and moved that The Council approve of the principles of the Michigan Health League as proposed in the draft of its Constitution and By-Laws. Seconded by Dr. Cummings and carried unanimously.

30. *Filter System.*—Councilor Cummings reported on the filter system in Washtenaw County. The Council felt that the Washtenaw County Medical Society and all other societies should be urged to continue their filter committee and work in connection with the Afflicted Child Law.

31. *Wisconsin's Study of Distribution of Sickness Care.*—A report on this activity was presented by Secretary Foster, who felt that a similar program might be attempted in Michigan in connection with the holding of "State Society Nights" in various parts of the state, at little additional expense. Motion of Drs. Barstow-Heavenrich that The Council approve this plan. Carried unanimously.

32. *Survey of Medical Relief Cases.*—The survey of 1937 medical relief, proposed by Dr. R. G. Tuck and recommended by Dr. R. H. Pino, was approved; motion of Drs. Haughey-Carstens that the M.S.M.S. request this information from the Michigan E.R.A. Carried unanimously.

33. *Use of Title "Dr."*—Secretary Foster reported on the request of a Grand Rapids citizen and a Lansing attorney that action be taken to limit the use of the title "Doctor" to those entitled to same. This matter was referred to the Legislative Committee, to the State Board of Registration in Medicine, and to such others as are interested in the problem.

34. *Placement Service.*—The Executive Secretary reported on activities to date. Several opportunities for a young physician were mentioned.

Dr. Manthei's report on the problem at Amasa was presented and ordered placed on file.

* * *

ELECTIONS

35. *Election of Secretary.*—Motion of Drs. Greene-Holmes that Dr. L. Fernald Foster be nominated to succeed himself as Secretary. Carried. Motion of Drs. Cummings-Heavenrich that the Secretary of this meeting be instructed to cast a ballot for Dr. Foster as M.S.M.S. Secretary. Carried unanimously. The Secretary did so cast, and Dr. Foster was announced by the Chair as Secretary of the M.S.M.S.

36. *Election of Treasurer.*—Motion of Drs. Moore-Brunk that Dr. Wm. A. Hyland be nominated to succeed himself as Treasurer. Carried. Motion of Dr. Moore, seconded by several, that the secretary of this meeting be instructed to cast the ballot for Dr. Hyland as M.S.M.S. Treasurer. Carried unanimously. The secretary did so cast, and Dr. Hyland was announced by the Chair as Treasurer of the M.S.M.S.

37. *Election of Editor.*—Motion of Dr. Holmes, seconded by several, that Dr. James H. Dempster be nominated to succeed himself as Editor. Carried. Motion of Dr. Cummings, seconded by several, that the secretary of this meeting be instructed to cast a ballot for Dr. Dempster as M.S.M.S. Editor. Carried unanimously. The secretary did so cast, and Dr. Dempster was announced by the Chair as Editor of the M.S.M.S. JOURNAL.

38. *Appointment of Executive Secretary.*—Motion of Drs. Carstens-Cummings that Wm. J. Burns be re-appointed as Executive Secretary. Carried unanimously.

Motion of Drs. Barstow-Sladek that Mr. Burns be given a vote of commendation and appreciation for his work in behalf of the M.S.M.S. Carried unanimously.

39. *Adjournment.*—The Mid-winter Meeting of The Council was adjourned at 4:00 p.m. The Chair thanked all for their attendance, patience, and good service.

The Councilors in turn expressed appreciation to Chairman Urmston for his hospitality and his efficiency in conducting this meeting.

Business Side of Medicine

(Continued from page 259)

March to June, went up in July and August, and tapered off again somewhere during the months of September, October or November.

(4) Both Business and Cash figures in 1937 were slightly more than 15 per cent higher than in 1936.

COUNTY SOCIETIES

ALPENA-ALCONA-PRESQUE ISLE COUNTIES

HAROLD KESSLER, M.D.
Secretary

The January meeting of the Alpena County Medical Society was held on January 28, 1938, at the Owl Cafe, Alpena. President W. E. Nesbitt of Alpena called the meeting to order.

The question of erection of a new hospital was discussed and the Secretary instructed to obtain as much information as possible relative to financing such a project and report to the Society next month.

The speaker of the evening, Dr. W. E. Nesbitt, spoke on "Pneumothorax." The talk was illustrated with the demonstration of the machine used in treatment, with numerous x-ray films showing the results obtained.

BAY-ARENAC-GLADWIN IOSCO COUNTIES

A. L. ZILIAK, M.D.
Secretary

The Bay County Medical Society held a regular dinner meeting Wednesday, January 12, 1938. Dr. Gordon Myers, Professor of Medicine at Wayne University, gave an interesting talk on "Pneumonia."

On January 26, the members heard Dr. John Barnwell of the University of Michigan give an illustrated talk on "Bronchitis and Bronchial Obstruction in the Tuberculous."

The Society decided to devote one meeting each month to a scientific paper and one meeting to business and sociability.

Two new members were received into membership: Dr. Harold Henser, Bay City, and Dr. Horace Burton, East Tawas.

BATTLE CREEK ACADEMY OF MEDICINE

L. R. KEAGLE, M.D.
Secretary

The Battle Creek Academy of Medicine and Dentistry held a dinner meeting on January 25, 1938, at the Kellogg Hotel, Battle Creek. Guests who were present included Mayor R. J. Hamilton, Battle Creek; Judge of Probate Frank Kulp, City Attorney Demond, Albion; Senator D. Hale Brake of Stanton, Victor Blain of ERA, Wm. J. Burns, Executive Secretary of the Michigan State Medical Society; Dr. Hugh Robins, County Health Officer, and William Morgan, Poor Commissioner.

The address of the evening was given by Senator Brake, who discussed fully the welfare legislation passed at the 1937 session of the Michigan Legislature. Senator Brake stated that the controversy over the welfare legislation should not be used as a political football. It should be considered on its merits. It is now a conflict between state and local control. The new bills secure local control more than any other. It is now on referendum and must be voted upon next November. Senator Brake urged the medical profession to support it as a measure eliminating much of the red tape that has hampered their work so long.

Mr. Burns spoke of the occupational disease law and of the necessity of familiarizing ourselves with the nomenclature of the thirty-one diseases listed therein. It is necessary that the exact terminology be used in reporting cases, else the patient will lose his compensation. Mr. Burns also spoke briefly on the afflicted and crippled children's laws, which require the republishing of the fee schedule every six months. Members of the medical profession were urged to send in suggestions. He suggested that syphilis control programs should be started by each county medical society, which, because of its technical knowledge, must assume medical leadership.

CALHOUN COUNTY

WILFRID HAUGHEY, M.D.
Secretary

The February meeting of the Calhoun County Medical Society was called to order by President J. E. Rosenfeld at the Post Tavern, Battle Creek, on February 4.

The president announced the appointment of a Cancer Committee. The names of the appointees are: Dr. Fred J. Melges, chairman, Drs. A. A. Humphrey, George W. Slagle, Russell L. Mustard, and Robert H. Fraser.

The secretary read a number of communications from the secretary of the State Medical Society regarding medical aspects of old age pensioners, afflicted children's law and new regulations, et cetera.

Application for membership was presented for Dr. Paul A. L. Black, second reading. By motion of Drs. Cooper and Slagle, he was elected.

First reading applications were presented for Dr. Hugh B. Robbins of Marshall and Dr. James D. Sleight of Battle Creek.

The speaker of the evening, Dr. F. Janney Smith of Henry Ford Hospital, Detroit, was introduced by Dr. Verity. Doctor Smith spoke on "Coronary Artery Disease."

DICKINSON-IRON COUNTIES

W. H. HURON, M.D.
Secretary

The February meeting of the Dickinson-Iron County Medical Society was held at the Crystal Inn at Crystal Falls, February 9, 1938. Fourteen physicians were present from the two counties.

The committee appointed for drafting a new constitution and by-laws reported the outline which had been sent out by the State Society, and this was accepted with such changes as were necessary for the local society.

Dr. E. M. Libby was elected as delegate to the 1938 meeting of the State Society House of Delegates, and Dr. W. H. Huron was elected as alternate. Dr. J. A. Crowell, of Iron Mountain, who has been practicing medicine in the Upper Peninsula for over fifty years, and who has retained an active membership, was elected a member emeritus. Dr. E. P. Lockart of Norway, who is now past 80 years of age, and who has practiced medicine in this vicinity for well over fifty years, was elected an honorary member of the society.

Dr. B. C. Baron gave a paper on the "Peridural Nerve Block." He reported twenty-nine cases that he had done in conjunction with Dr. Harry Haight of Crystal Falls.

EATON COUNTY

THOMAS WILENSKY, M.D.
Secretary

The January meeting of the Eaton County Medical Society was held in Charlotte on January 27, 1938.

Immediately following dinner, President H. A. Moyer introduced the speaker, Dr. J. F. Harrold, urologist, of Lansing, who read a most comprehensive and detailed paper entitled "Sulfanilamide in Urologic Infections." Doctor Harrold was one of the first to use sulfanilamide in urologic infections, and particularly in gonococci infections, and he is most enthusiastic about it, for carefully controlled cases showed decidedly better results than did similar cases treated before sulfanilamide.

The secretary spoke briefly on the discussions which took place at the County Secretaries' Conference held in Lansing on January 23.

The following resolution was presented and adopted unanimously:

"WHEREAS, Dr. J. B. Bradley of Eaton Rapids and Dr. Phil Quick of Olivet having each through personal integrity and constant adherence to Hippocratic concepts of medical practice, erected to themselves towering monuments in the form of fifty years of professional service to their respective communities, therefore,

"BE IT RESOLVED that the Eaton County Medical Society goes on record as urging the House of Delegates of the Michigan State Medical Society to confer upon these two honorable practitioners lifelong and honorary membership in the Michigan State Medical Society."

The Society voted to hold the regular meetings on the third Thursday of the month instead of the last Thursday because of recurring conflicts with various holiday events throughout the year.

The condolences of the Society are sympathetically extended to Dr. Phil Quick, who is confined by illness.

HILLSDALE COUNTY

E. G. MCGAVRAN, M.D.
Secretary

The Hillsdale County Medical Society held two meetings in January, both taking place outside the county.

On January 18, the Hillsdale and Jackson Societies were joint sponsors of a State Officers Meeting, held at the Hayes Hotel, Jackson.

The second meeting of the month was held on January 20 at Sweet's Hotel, Quincy. This was a joint session of the medical societies and veterinarians of Branch and Hillsdale Counties. Dr. B. W. Culver of Coldwater presided. The speaker of the evening, Dr. Paul Brooks, deputy commissioner of health of New York State, was introduced by Dr. R. B. Harkness of Hastings.

Dr. Brooks gave a very interesting address on the subject of "Milk-Borne Outbreaks of Communicable Disease" which was illustrated by a chart of all such outbreaks that have occurred in New York State during the past twenty years. This talk illustrated, forcibly, the need for pasteurization of milk supplies to avoid such outbreaks. Following his address, Dr. Brooks answered a number of questions and particular interest was shown in the new test to determine satisfactory pasteurization of milk on the basis of the presence or absence of a certain enzyme.

HURON-SANILAC COUNTIES

E. W. BLANCHARD, M.D.
Secretary

The annual meeting of the Huron-Sanilac County Medical Society was held at Marlette, January 25, 1938, with thirteen members and two guests present. The following officers were elected:

President—R. R. Gettel, Kinde.
Vice President—R. K. Hart, Croswell.
Secretary-Treasurer—E. W. Blanchard, Deckerville.
Delegate to M.S.M.S.—C. J. Webster, Marlette.
Alternate Delegate—C. W. Oakes, Harbor Beach.

Short talks were given on State Society affairs by Dr. L. Fernald Foster, secretary of the Michigan State Medical Society, and Dr. Paul R. Urmston, chairman of The Council, both of Bay City.

Dr. J. O. Lunn addressed the Society on "Iodine in Relation to Thyroid Disease."

INGHAM COUNTY

R. J. HIMMELBERGER, M.D.
Secretary

The annual President's Dinner was held on January 11, 1938, with 178 members and guests present. Dr. Byron Niles acted as toastmaster, and introduced the retiring president, Dr. Milton Shaw, who spoke briefly of the advances made by the Ingham County Medical Society during the past twenty years.

The new president, Dr. Dana M. Snell, was then introduced and he immediately ordered a meeting to be called as a special meeting. Dr. L. C. Towne was recognized by the president and presented a resolution expressing the gratitude and deep appreciation of the Ingham County Medical Society to Dr. Milton Shaw for his long continued self-sacrifice in rendering unselfish service to this community by doing autopsies, and authorizing a committee to be appointed to purchase a suitable token as visible proof of the recognition of this unparalleled service to medicine. The resolution was unanimously adopted and a copy was presented to Doctor Shaw.

IONIA-MONTCALM COUNTIES

JOHN J. MCCANN, M.D.
Secretary

The January meeting of the Ionia-Montcalm Medical Society was held on January 11, 1938, at the Reed Inn, Ionia, with Dr. R. R. Whitten, newly elected president, in the chair. Twenty-one members were present. Dr. David B. Davis and Dr. Paul W. Kniskern, both of Grand Rapids, were guests.

Dr. Davis presented a paper entitled "Head Injuries," giving his talk from the viewpoint of the general practitioner. Dr. Kniskern spoke on the practical phases of blood-transfusion.

President Whitten appointed the following committees:

Cancer.—Drs. R. C. Lintner, A. J. Bower, M. A. Hoffs, I. S. Lilly and John R. Hay.
Public Relations.—Dr. C. T. Pankhurst, Chairman.
Constitution and By-Laws.—Drs. P. C. Robertson, W. W. Norris, L. S. Dunkin.
Membership Committee.—Drs. J. A. VanLoo, V. F. Kling, and M. M. Hansen.

OTTAWA COUNTY

D. C. BLOEMENDAAL, M.D.
Secretary

The February meeting of the Ottawa County Medical Society was held Tuesday, February 8, 1938, at the Wm. M. Ferry Hotel, Grand Haven. Twenty members were present. Following a short business session, the meeting was turned over to Dr. Lynn A. Ferguson of Grand Rapids, who spoke on "Rectal Infections." His talk was illustrated with lantern slides.

WOMAN'S AUXILIARY

President—Mrs. G. C. Hicks, 1009 Wildwood Ave., Jackson, Michigan
Sec.-Treas.—Mrs. J. W. Page, 119 N. Wisner St., Jackson, Michigan
Press—Mrs. C. B. Fulkerson, 1535 Grand Ave., Kalamazoo, Michigan

ITEMS FROM THE STATE SECRETARY

A doctor's wife from an unorganized county writes:

"Because I feel it should be the duty of every doctor's wife to support the Auxiliary at least by membership, I am requesting the necessary blanks."

Perhaps there are other doctors' wives living in unorganized counties who feel the same—remembering, of course, that their husband must be a member of the county medical society for a wife to be eligible. A note to the Treasurer will secure the blanks. When these are filled out and returned with the $1.00 fee, one becomes an Associate Member of the State and National Auxiliary. While such membership lacks the benefit and pleasure which comes from the contacts within a County Auxiliary, it is a fine way of expressing appreciation of the program and purposes of the organization.

* * *

The prize for promptness (perhaps we really should have one to award) goes to the Monroe County Auxiliary who remitted State and National dues in full on January 16.

* * *

The Mid-Winter Board meeting of the Woman's Auxiliary to the Michigan State Medical Society was held at the Hayes Hotel, Jackson, on December 6, 1937.

The meeting was called to order by the President, Mrs. Hicks. The following members of the Board answered roll call: Officers and Chairmen: Hicks, Urmston, Page, Wenger, Jeanichen, Ziliak, Pyle, Geib; County Presidents: Howard, Anderson, Vanderzalm, Ludwick, Lang, Snapp, Harvie, Walker.

The minutes of the Pre-Convention and Post-Convention Board meetings were read and approved. The Secretary took the chair while the President presented her report. The Treasurer's report disclosed a balance of $353.53. Reports from standing committees followed: Advisory Committee, Program, and Public Relations. The Chairman of the Committee on Organization was present, but had no report to make. Both Press Chairman and Legislative Chariman were kept away by illness. A report from the Press Chairman was read by the Secretary. All these reports were approved.

County Presidents from Bay, Calhoun, Eaton, Jackson, Kalamazoo, Kent, Saginaw, and Wayne County Auxiliary reported on the progress of their program. A report from the President of the Monroe County Auxiliary was read by the Secretary.

The Chairman on Revision, Mrs. Geib, reported the printing of 200 copies of the newly adopted Constitution and By-laws and produced them for distribution.

The Treasurer reported that the plan for a card index, as decided upon at the last meeting of the Board, had been dropped, since the experience of the National Auxiliary had led them to conclude that difficulty in getting coöperation made the plan valueless, so they were no longer supplying the cards.

Mrs. Wenger reported that a study of the matter of a state project showed no money available;

she then gave a comprehensive summary of the contents of the National News Letters for 1936-37.

Proceeding to new business, Mrs. Snapp moved and Mrs. Howard seconded her motion that pins should be purchased for the Past Presidents, as well as one to be worn by the acting President. The motion was carried.

Mrs. Wenger moved, seconded by Mrs. Harvie, that the President be sent to the National Convention with expenses paid. The motion was carried.

Mrs. Wenger moved, seconded by Mrs. Geib, that the President-elect be sent to the National meeting with expenses paid. The motion was carried.

Mrs. Wenger moved and Mrs. Ziliak seconded her motion that traveling expenses to the mid-year Board be paid, with an allowance of $0.06 per mile. The motion carried.

The President declared the meeting adjourned.

(Mrs. J. W.) Ethel Boyd Page, *Secretary*

COUNTY AUXILIARIES

Bay County

The Auxiliary met December 15, at the home of Mrs. W. S. Stinson. Thirty-two members were present. After the pot-luck dinner, the business meeting was opened by the president, Mrs. A. L. Ziliak. Mrs. A. D. Allen, *Hygeia* chairman, reported a net profit of thirty-five dollars from a Keno party, given for doctors and their wives, and was instructed to turn this money toward subscriptions for *Hygeia* magazine for the rural schools of our county.

As our membership is becoming too large to be accomodated in private homes, we accepted the offer to hold all future meetings of the year at the Elizabeth Riley Nurses' Home of Mercy Hospital, the dinners to continue to be pot-luck.

On January 12, the Auxiliary met at the Nurses' Home of Mercy Hospital. Thirty-four members were present. Mrs. Ziliak reported that Dr. Brakey of Lansing had been secured to speak here on February 9, his subject to concern the education of the public concerning syphilis. This was counted as our second Public Relation Meeting and was open to the public, free of charge.

Following the business meeting we listened to a very interesting speech by Mrs. Beckwith, supervisor of all work with handicapped children in the public schools of Bay City.

A Benefit Card Party and Tea was held on Valentine's Day at the Nurses' Home.

(Mrs. W. S.) Lynn J. Stinson,
Corresponding Secretary

Ingham County

On Monday, January 17, the Auxiliary met for an all day sewing meeting at Saint Lawrence Hospital. Mrs. Frank Stiles, chairman of the Welfare Committee, was in charge, and was capably assisted by Mrs. H. A. Wilson, Vice Chairman. Although only a small number attended, the group accomplished a considerable amount of work, making 214 towels, twenty-eight dresser scarfs, forty-nine sheets, and ten pillow cases. Coffee was served at noon by the hospital.

Dr. Clara M. Davis of Chicago, formerly of Lansing, was the guest speaker at the meeting of the auxiliary Monday afternoon, January 24, at the Y.W.C.A. Mrs. G. C. Hicks, state president, and Mrs. J. W. Page, state secretary, both of Jackson, were also guests.

Doctor Davis, a member of the pediatrics staff of Children's Memorial hospital, Chicago, spoke on "Human Relationships with Children."

Tea was served at a table gay with a spring bouquet of daffodils, freesia, and snapdragons. Yellow tapers burned in five-branch silver candelabra. Mrs. C. P. Doyle and Mrs. A. M. Campbell presided at the services.

Mrs. Fred Drolett, chairman, was assisted by Mrs. C. B. Gardner, Mrs. Fred Huntley, and Mrs. William Cameron.

Mrs. P. T. VanderZalm, president of the auxiliary, presided and Mrs. H. S. Bartholomew, program chairman, introduced the speaker.

Mrs. P. C. Strauss,
Press Chairman

Eaton County

The Woman's Auxiliary met on January 27, at the home of Mrs. John Lawther for a pot-luck dinner. Eighteen members were present. Following a short business meeting, when it was decided to give specified maternity supplies to the Kellogg Foundation for distribution throughout the county, a baby shower was given for the five months old baby recently adopted by Dr. and Mrs. L. G. Sevener of Charlotte.

Mrs. B. P. Brown,
Press Chairman

Jackson County

The January meeting of the Women's Auxiliary was held in the home of Mrs. W. L. Finton, Tuesday evening, January 18. Fifty-seven members were present. The dinner, which was prepared by the Homade Company, was in charge of the following committee—Mesdames R. M. Cooley and M. J. McLaughlin; co-chairmen, G. R. Bullen, C. E. DeMay, George C. Hardie and John W. Page.

At a short business meeting it was voted to undertake service projects for the two local hospitals. It was also suggested by the *Hygeia* Committee, and voted upon, to solicit *Hygeia* subscriptions from the physicians.

During the social hour, Mrs. Myron Susskind conducted a "Professor Quiz" contest. Later bridge was played.

Anna Hyde Shaeffer,
Press Chairman

Kalamazoo County

A most enjoyable meeting of the Woman's Auxiliary was held at the home of Mrs. W. W. Lang on January 18, 1938.

After a coöperative dinner Mrs. William McKinley Robinson charmingly entertained us with a talk on her recent trip to the Orient. Mrs. Robinson compared the characteristics and mode of living of the Japanese with the Chinese which was most interesting and instructive.

A brief business meeting followed. Mrs. R. W. Shook reported that our gifts to the old people at Christmas had been gratefully acknowledged and Mrs. W. D. Irwin stated that the tuition of the deaf child had been paid to the Harding School.

Thirty-six members and four guests were present.

(Mrs. Hugo) Barbara K. Aach,
Publicity Chairman

Kent County

The Woman's Auxiliary met in the afternoon of January 12, in the club rooms of the society. Mrs. J. B. Whinery was the speaker of the afternoon, using as her topic "My Impressions of Russia." Mrs. E. S. Sevensma and Mrs. H. C. Swenson were the hostesses in charge of the tea served after the meeting.

Mrs. F. A. Votey is preparing an article for the

year book of the Federation of Garden Clubs on "Marijuana." She is chairman of the conservation committee for the Federation of Garden Clubs.

The *Hygeia* Committee, Mrs. Wm. Butler, chairman, worked hard to make every member of the auxiliary a subscriber to *Hygeia* before the end of January. They succeeded in lining up 101 subscriptions out of a possible 110.

We are looking forward with interest to the meeting February 9, when Dr. John Lavan will speak on "Food Handling Facts."

(Mrs. Robert) MIRIAM ADAMS EATON

Monroe County

The Woman's Auxiliary held a dinner and business meeting at the Monroe Country Club on January 20. Plans were made for a Valentine Bingo Party at which the members of the Medical Society are to be our guests.

A social hour followed.

(MRS. VINCENT) MARTHA BARKER,
Press Chairman

Saginaw County

Thirty-eight members of the auxiliary met January 18, at the home of Mrs. Victor L. Hill, to hear Chester E. Miller speak on school needs. Mrs. L. C. Harvie presided. Later bridge was enjoyed.

MRS. A. E. LEITCH,
Press Chairman

Among Our Contributors

Dr. S. Stephen Bohn was graduated from the University of Michigan Medical School in 1933. He served his interneship at St. Joseph's Mercy Hospital, Ann Arbor, and he spent one year as house physician at Mercywood Sanitarium, Ann Arbor. He took a two-year training course at the Neurological Institute of New York after which he received the degree of Doctor of Medical Science in Neurology from Columbia University. Dr. Bohn is on the outpatient staff of Harper and Receiving Hospitals, Detroit. His practice is confined to neuropsychiatry.

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Dr. O. S. Brines is Assistant Professor of Pathology at Wayne University and Pathologist at Receiving Hospital, Detroit. He is Chairman of the Cancer Committee of the Michigan State Medical Society.

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Dr. L. C. Grosh, Jr., was graduated from the Johns Hopkins Medical School in 1930. He served as instructor in the Department of Medicine, University of Michigan Medical School, 1932 to 1934. He has been Assistant Physician at the Ypsilanti State Hospital, Department of Research since 1935.

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Dr. George P. Reynolds was graduated with the degree of A.B. from Harvard University in 1920 and M.D. in 1924. His practice is limited to internal medicine. Dr. Reynolds is instructor in medicine, Harvard Medical School, Junior Visiting Physician of the Boston City Hospital.

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Dr. Loren Shaffer is Chairman of the Advisory Committee on Syphilis Control of the Michigan State Medical Society, Director of the Social Hygiene Division, Detroit Department of Health, and Professor of Dermatology and Syphilology, Wayne University, College of Medicine, Detroit.

MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner
LANSING, MICHIGAN

DR. GUDAKUNST OUTLINES PROGRAM

Four conditions which must be met by the health and medical agencies of Michigan in a long-range program to improve the health of the citizens of this state were outlined by Dr. Don W. Gudakunst on February 1 when he assumed his office as State Commissioner of Health.

To adequately conserve and promote the health of the people, said Dr. Gudakunst:

"(1) There must be a general knowledge of the need and value of medical services in times of health as well as sickness; (2) there must be adequate and competent medical services readily available; (3) there must be both social and mechanical facilities for providing medical care; and (4) provision must be made for payment for these services dependent upon the economic status of the recipient.

"If these four requirements were fully met throughout the state, there would be but a minimum expenditure for care of the handicapped and permanently incapacitated. Public health would be raised to the highest level imposed by the hereditary limit of the people.

"Education of the people in respect to medical care must be directed to the intelligence levels of the various groups in the community. We must reach not only the intelligent but those whose thinking processes are slow or who are prejudiced through lack of training. This will call for the closest coöperation between educational leaders and health specialists.

"One of the functions of the health department is to extract the usable information from the mass of scientific data available and then to pass this on to patients and physicians alike. Fads, fancies, foibles come and go. These must be separated from the sound.

"Postgraduate education in medicine is recognized by all as an absolutely essential need. The physicians coming from our schools must be kept up to date. It is the function of the health department to aid the medical schools and the state and county medical societies in their programs of education. Physicians, as others, cannot all be reached entirely by mass action. There is a great need for individual contact of and discussion with practicing physicians relative to preventive medical services. This may well be done by the State Department of Health.

"Undergraduate medical education can and must be improved along many lines. Today the clinical teaching is excellent in most respects, but the social and public health aspects of sickness have not been stressed in medical schools. A great opportunity is afforded the State Health Department to aid in supplying a more adequate training aimed at meeting the new problems.

"While there are many counties with full-time health departments, there are still 25 counties not so served. These are, for the most part, in the more densely settled areas. There is an inadequacy of hospital care and there is an unequal distribution of medical men. The county hospitals are today so organized that they largely serve to care for only the end-results of lack of adequate medical care—they are not prepared to render medical services

when such would be most efficient and least expensive.

"Medical care costs money. Within certain limits not only public health but individual health is purchasable and is always worth paying for. If an individual cannot pay for his own medical care then that individual is very likely to become a welfare charge of the state. There is a vicious circle between poverty and disease—each contributing to and speeding the other. In the interest of public health and economy, this circle must be broken. It is the task of the State Department of Health, the foundations developed for health promotion, and the organizations of practicing professional people to devise some way for giving medical service to those who are not now getting it.

"This program is not for government alone—but for all the people of the state. It is not to be put into effect without additional funds made freely available by the people. Such spending must be done, but it will yield the greatest financial returns of any public investment. For a time we must pay for the neglect of the past and must add to this cost the price of prevention. This will eliminate a large part of the cost of caring for the destitute, chronic sick.

"This is a long time program measured in terms of generations—not merely weeks or months."

HEALTH WORKERS' TRAINING CENTER

Practical field training of public health personnel will become a reality under the coöperative training center which is being established in conjunction with the recently created Ingham County Health Department, according to Dr. Don W. Gudakunst, state health commissioner.

The new training center will enable selected graduates from academic public health courses to become familiar with rural health practices in the field. The training center will provide Michigan with a constant supply of experienced public health personnel. Health officers, sanitary officers and public health nurses will be given training extending over various periods from three months to a year under the supervision of well-qualified instructors.

While primarily a health department, the local health unit will operate the training center as an additional function in coöperation with the University of Michigan and the Michigan Department of Health. The personnel of the Ingham County Health Department will include a director, an assistant director, a supervising nurse and five public health nurses, a chief sanitary inspector and one assistant, a chief statistical clerk and an assistant. Selected students, upon completion of their academic public health studies, will be awarded scholarships at the training center and will carry on actual health work under the direction of the department personnel.

The Ingham County Health Department offers a unique example of coöperative endeavor in the promotion of local health protection. With a total budget of $34,600, the new unit will receive $11,100 from local appropriations, $3,000 under state law from the Michigan Department of Health and $4,500 from the Social Security funds allotted to the U. S. Public Health Service.

The Children's Fund of Michigan has allotted $10,000 for the maintenance of the training facilities and an additional $6,000 will come from the maternal and child health funds administered by the Michigan Department of Health.

MATERNAL AND CHILD HEALTH CONFERENCE

Michigan's program for the promotion of maternal and child health during the past 21 months since Social Security funds became available was reviewed by the 32 representatives of major health and welfare agencies meeting at Lansing, January 26 for the second annual conference of the General Advisory Committee on Maternal and Child Health, sponsored by the Michigan Department of Health.

Dr. Lillian R. Smith, director of the department's Bureau of Maternal and Child Health, presided at the conference and outlined the work which has been carried on with the aid of an annual federal allotment of approximately $100,000. In all cases, said Dr. Smith, local programs are carried on with the advice and coöperation of the county medical societies.

The scope of the program outlined by Dr. Smith included child care classes in the rural schools of 33 counties, women's classes in 26 counties, maternal and child health nursing services in 13 counties, maternity nursing service in 11 counties, a demonstration maternity nursing service in St. Clair County, a home delivery nursing service in Cass County, refresher courses for physicians in 13 counties, nutrition institutes in 18 counties, the production of an educational film on prenatal care for showing before lay audiences, and the postgraduate training of public health nurses.

The conference representatives were welcomed by Dr. Don W. Gudakunst, State Health Commissioner, who declared "We all have our ideas of what should be done and it is through meetings such as this that we can exchange ideas, formulate a program, and, what is more important, carry that program into the field and put it into operation."

Dr. Alexander M. Campbell, acting chairman of the Advisory Committee, reported as follows: "As chairman of the Committee on Maternal Health for the State Medical Society, I wish to say that our relations with the Michigan Department of Health, the University of Michigan, and with the State Society have been very pleasant and very cooperative. You might be interested to know something about the activities in which we engaged.

"Through the coöperation of these agencies and a program outlined by Dr. Smith, I gave a five weeks' course in obstetrics in the northern part of the Lower Peninsular. In every case I met with a great deal of enthusiasm. I met with some opposition at first because they thought there might be some politics behind it, but when they understood, we were received cordially. In the whole five weeks, nothing unpleasant occurred. There is no question but what the physicians of the state are deeply interested in improving the quality of their obstetrics."

Dr. Henry Cook, president of the State Medical Society, expressed the conscensus of the group when he proposed the coördination of all branches of preventive medicine in order that "we may help each other more and help the whole group." He said that interest in preventive medicine is growing rapidly among physicians and that the society is willing to coöperate in a coördinated program to improve maternal and child health.

The place that maternal and child health problems have occupied in the extra-mural teaching program of the University of Michigan was discussed by Dr. James D. Bruce, vice president and director of postgraduate medicine. Dr. Bruce declared that the University would be delighted to devote one day to maternal welfare and one day to child wel-

fare out of the eight-day postgraduate program offered physicians.

In commending the Joint Committee on Health Education with its twenty-five member agencies as an excellent medium for coördinating health education programs, Dr. Bruce declared, "Your maternal and child welfare programs must of necessity reach the people of the state, their mothers and children. It must teach every group as well as the professional group. If we do not get that consciousness of health over to lay groups, the best possible provision on the part of the doctors will not meet the situation. And, on the other hand, the greatest appreciation of good medical service on the part of the public will be of very little value unless you have a profession prepared to meet that need. There is in the Joint Committee a group of agencies which will permit the widest possible dissemination of health knowledge."

An immunization schedule which has been tentatively approved by the Michigan Department of Health, the State Medical Society and the Michigan Branch, American Academy of Pediatrics, was presented by Dr. F. B. Miner of Flint, representing the Academy. This immunization schedule is as follows: 3-6 months—Pertussis for whooping cough; 9 months—Diphtheria immunization; 12 months—Smallpox vaccination; 15 months—Schick test; Tuberclin tests recommended at 3, 6, 9, 12, and 15 years; and use of iodized salt is advised.

Organizations represented at the conference included the Michigan State Medical Society, Michigan State Dental Society, State Nurses' Association, Children's Fund of Michigan, W. K. Kellogg Foundation, Michigan State College, State Welfare Department, State Department of Public Instruction, Michigan League of Women Voters, the Maccabees, Daughters of the American Revolution, Michigan Child Study Association, Michigan State and National Grange, American Academy of Pediatrics, Michigan Crippled Children Commission, University of Michigan, State Organization for Public Health Nursing, and the Michigan Department of Health.

ROUTINE GROUP LABORATORY EXAMINATIONS LIMITED

Local health officers have been notified by the Michigan Department of Health that routine group laboratory examinations of specimens from food handlers and industrial workers will not hereafter be done by the Department laboratories at State expense.

The Department, however, does not wish to disparage the value of individual patient studies. Requests for routine laboratory examinations of food handlers and industrial workers have increased to such an extent that if all requests were granted the basic functions of the laboratories would be seriously handicapped. Routine laboratory examinations of specimens from food handlers do not help in the control of communicable diseases and similar examinations of specimens from industrial workers are of little public health significance, the Department pointed out.

The laboratories of the Michigan Department of Health function basically as an aid to physicians and health officers in the diagnosis and control of communicable diseases and the maintenance of a high standard of environmental sanitation. Current demands on the laboratories for these fundamental examinations are taxing the available facilities to the limit. If specific problems concerning group examinations arise, however, the Department will be glad to confer with local health officials regarding satisfactory methods of solution.

COMMUNICABLE DISEASE REVIEW FOR 1937

The incidence of tuberculosis, diphtheria, scarlet fever, measles, smallpox, poliomyelitis, syphilis and gonorrhea for 1937, according to reported cases, exceeded that of 1936. Those diseases in which the reported number of cases was less than for the preceding year were pneumonia, typhoid fever, whooping cough and meningococcic meningitis. Consideration of the communicable disease situation does not lead us to the conclusion that the incidence in all cases was increased to the extent that the figures would indicate.

A total of 6,469 cases of tuberculosis was reported for 1937 which is an increase of 1,312 over 1936. This, in reality, is an indication of a better degree of public health work. More cases were discovered by physicians and more cases were reported. It is believed that there was no increase in the actual number of cases occurring. Although figures for the twelve months are not complete as to the number of deaths, mortality for the first eleven months of the year increased from 1,938 in 1936 to 1,965 in 1937.

As stated in previous issues, it is evident that there has been a genuine increase in the incidence of diphtheria. The final figure for the year was 842 reported cases as compared to 661 for 1936. All evidence at hand indicates that it is the lack of immunization which makes possible such increases. Cases are occurring very largely in those who have never had active immunization.

The greatest increase in incidence in any disease is in scarlet fever. The final number of cases for 1937 was 24,798 as compared to 12,650 for the previous year. The number for 1937 exceeds by more than 5,000 that of any other year on record. Part of this increase is undoubtedly due to better diagnosis, discovery of more mild cases, and better reporting. But unquestionably there was a high incidence for the year.

The total number of reported measles cases for 1937 was 6,154 as compared to 2,453 for 1936. The incidence in 1936 is the lowest on record. The increase in 1937 was to be expected. It occurred principally in the latter months of the year and was in reality the beginning of the rise in the anticipated outbreak of 1938.

The increase in smallpox has been referred to in former issues of the JOURNAL. The final total of reported cases was 152. The larger part of these were definitely traced to one outbreak originating in Dundee. There were only 32 cases reported in 1936, the lowest year on record. At the present time there is some evidence of smallpox appearing in other parts of the state, particularly in the western part of the Upper Peninsula. Smallpox is not an extinct disease and doctors generally should be on the alert for it.

The increased incidence in poliomyelitis for 1937 received a great deal of publicity. The total number of cases reported was 421, which is almost three times the number reported in 1936. However, there have been several years during the last generation in which the number of reported cases has exceeded that for 1937.

The total number of cases of syphilis reported for 1937 was 8,708 as compared to 6,401 for 1936, and for gonorrhea, 7,072 cases in 1937 compared to 6,460 in 1936. These increases are, undoubtedly, due to the focusing of attention by the public and medical profession on venereal diseases and the importance of their control. In other words, it is due to better reporting brought about by publicity which is a part

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of the revived control program. It represents a small part of the total cases actually occurring and is, we believe, only the beginning of a much larger and more complete reporting which is a necessary part of any successful control program.

SMALLPOX IN THE UPPER PENINSULA

Smallpox has been rather prevalent in Gogebic County during recent months and is now beginning to appear in other parts of the Upper Peninsula. The first four cases of this outbreak to be officially reported were from Bessemer in November, 1937. During succeeding weeks, cases were reported as follows:

Place	*No. Cases*	*Date Reported*
Wakefield, Gogebic County	1	1-13-38
Watersmeet Twp., Gogebic County	1	1-13-38
Houghton Village, Houghton County	2	1-17-38
Bergland Village, Ontonagon County	1	1-19-38
Houghton Village, Houghton County	1	1-21-38
Bessemer, Gogebic County	1	1-21-38
Bergland Village, Ontonagon County	3	1-24-38
Ontonagon County	2	1-31-38

In spite of the fact that only a few cases were being reported during November and December and January, rumors persisted that smallpox was quite prevalent. Therefore, a field epidemiologist was sent from the Department to investigate. It was then discovered that there had been an epidemic in Wakefield for some time past and that perhaps there had been several scores of mild cases which were missed either because of not having medical attention or the diagnosis was not properly made. One such individual was on the federal jury at Marquette during January and became ill during his last day of service. Other men on the jury came from various parts of the Upper Peninsula.

It is only the high percentage of vaccinated people residing in the towns of the western part of Gogebic County that has thus far prevented smallpox from becoming extensive. It is apt to spread to other communities and become an even greater menace if such communities are not well vaccinated.

INGHAM AND MUSKEGON COUNTIES TO ORGANIZE HEALTH DEPARTMENTS

Ingham and Muskegon counties will organize full-time county health departments following favorable votes of their respective boards of supervisors in January. The addition of these two populous counties will make a total of 58 of Michigan's 83 counties now provided with full-time local health departments.

IN MEMORIAM

Dr. Samuel R. Turner

Dr. Samuel R. Turner, of Michigan Center, died on February 7, 1938, following a stroke. Dr. Turner was born at Freeport, Illinois, in 1858. He was graduated from the University of Louisville Medical School in 1888 and began his practice at Dyer, Indiana. He moved to Bronson, Michigan, in 1904 and in 1923 located in Michigan Center. Dr. Turner was a past-president of the Branch County Medical Society. He is survived by his wife, three married daughters and a son, Dr. Harold B. Turner, who is a practicing physician in Bloomfield, Indiana.

General News and Announcements

The One Hundred Per Cent Club of the Micigan State Medical Society

1. Ingham County Medical Society
2. Luce County Medical Society
3. Muskegon County Medical Society
4. Newaygo County Medical Society
5. Oceana County Medical Society
6. Ontonagon County Medical Society
7. Shiawassee County Medical Society

These county medical societies are the first to record 100 per cent paid membership for the year 1938. Dues for 1938 are now payable and are being received daily from the various county medical society secretaries. See your County Secretary today and help your Society become one of the first members of the "One Hundred Per Cent Club for 1938."

The St. Joseph and Branch County Medical Societies are planning a "State Society Night" which will be held at Sturgis in April.

* * *

Past-President Henry E. Perry is sojourning in Lakeland, Florida. His address is 202 Paloma Avenue, Lakeland. He reports that he is in the best of health and spirits.

* * *

For hotel reservations in San Francisco for the A.M.A. meeting, write Dr. F. C. Warnshuis, 450 Sutter Street, San Francisco. Give the names of members of your party, type of accommodations desired, rates, dates of arrival and departure.

Dr. E. D. Busby, Associate Professor of Surgery, University of Western Ontario, gave a talk on the subject of "Haematuria" before the members of the Genesee County Medical Society at its meeting of February 2, 1938.

* * *

The Committee on Scientific Work of the Michigan State Medical Society held a meeting at the Olds Hotel, Lansing, on February 20, to develop the scientific program and presentations for the 1938 annual meeting, in Detroit, September 20, 21, 22.

* * *

Dr. Mary Margaret Frazer of Detroit and *Dr. Lillian Smith* of Lansing were elected president and secretary, respectively, of the Michigan Branch of the National Women's Medical Association at their annual meeting in Grand Rapids last September.

* * *

I. M. Wieder, of the National Discount & Audit Company, announces the appointment of M. G. Sweitzer of Lansing as representative in Michigan outside of Wayne County. Mr. Sweitzer will maintain an office at 800 American State Bank Bldg., Lansing.

* * *

Dr. Frank A. Kelly of Detroit has been elected chief of the surgical staff of Grace Hospital. Dr. Charles S. Kennedy was named vice-chief. Doctor Kelly is a past-president of the Wayne County Medical Society.

Dr. Kelly addressed the Honolulu Medical Society on March 3. His subject was "The Injection Treatment of Hernia."

Have You Moved?

It is important that the mailing list of THE JOURNAL of the M.S.M.S. be kept up to date and accurate. Members are invited to help THE JOURNAL in this work. When and if you change your mailing address, please drop a card to THE JOURNAL, giving your new address. If you would like to have your copy of THE JOURNAL sent to your home instead of your office (or vice versa), write the Executive Office, 2020 Olds Tower, Lansing. Please submit changes in address promptly to assist THE JOURNAL in avoiding delay in making mailing list revisions. We desire to have THE JOURNAL reach you each month without delay.

Dr. W. G. Maddock of Ann Arbor gave a demonstrative lecture on the roadside care of the injured preparatory for transportation to the hospital, before the members of the Hillsdale County Medical Society at its meeting held in Hillsdale on February 17.

* * *

The Cleveland Academy of Medicine has adopted the principle that applications for membership from physicians who are graduates of foreign universities and who have been residents of this country only a short time shall be tabled automatically for two years.

* * *

Dr. James D. Bruce, Director, Department of Postgraduate Medicine of the University of Michigan, presented a paper entitled "Continuing Professional Education" at the Thirty-fourth Annual Congress on Medical Education and Licensure held in the Palmer House, Chicago, on February 14 and 15.

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Dr. P. R. Urmston and *Dr. L. Fernald Foster* of Bay City were guests of the Huron-Sanilac County Medical Society at its meeting on January 25, at Marlette. Doctors Urmston and Foster discussed the activities of the Michigan State Medical Society.

* * *

Dr. S. W. Donaldson of Ann Arbor has been appointed by President Henry Cook as a member of the Liaison Committee with the State Bar of Michigan, and also by The Council as a member of the Executive Board, Medical Defense for the coming year.

* * *

The annual dinner dance of the Wayne County Medical Society was held at the Detroit Golf Club on February 26. This social evening is always a pleasant and enjoyable function, attended by hundreds of members and their guests. Details were arranged by the Entertainment Committee of the Society.

* * *

"Does your firm advertise in The Journal of the Michigan State Medical Society and does it exhibit at the annual conventions of the M.S.M.S.?" Ask this question of all detail men who seek your business.

Those firms which you patronize should in turn support you.

* * *

The Bay County Medical Society adopted a resolution whereby the Society decided to devote one of its two meetings each month to the transac-

tion of business and the other to general sociability. The volume of society business has increased to such an extent that it requires the time of a whole meeting.

* * *

Dr. Robert S. Breakey of Lansing spoke at a public meeting in Bay City on the subject of "Syphilis," on February 9. The meeting was sponsored by the Woman's Auxiliary of the Bay County Medical Society and was held at the Nurse's Home, Mercy Hospital, He also addressed 1,500 high school children on "Keeping Fit."

* * *

The Third Annual Postgraduate Institute, offering an intensive and interesting study of the Diseases of the Digestive Tract, will be conducted by the Philadelphia County Medical Society from March 28 to April 1, inclusive, in the Bellevue-Stratford Hotel, Philadelphia. Information may be secured from the Philadelphia County Medical Society, 21st and Spruce Streets, Philadelphia, Pennsylvania.

* * *

The Wayne County Medical Society has issued a small sticker listing the various radio programs sponsored by national, state and county medical organizations, which are carried by Detroit radio stations. These announcements are being distributed to the membership of the W.C.M.S with the suggestion that one be attached to statements and correspondence going to patients. The sticker is entitled "Medicine . . . on the air."

* * *

Speakers on scientific subjects are available for county medical societies. Write the Executive Office, 2020 Olds Tower, Lansing, for talks on:

Cancer
Maternal Health
Mental Hygiene
Syphilis
Tuberculosis
Preventive Medicine
Social Aspects of Sickness
Occupational Diseases.

* * *

Dr. J. D. Brook of Grandville, one of Michigan's delegates to the American Medical Association House of Delegates, has been honored by being selected as a member of the first Committee on Distinguished Service Awards of the A.M.A., a five-man board. This committee is authorized to receive nominations for the award, to be given annually on the basis of meritorious service in the art and science of medicine. The award will include a distinguished service medal and a citation.

* * *

Acting Comptroller-General Elliott has declared illegal the group medical plan for employees of the Home Owners Loan Corporation, Washington, D. C., financed by $40,000 of Federal funds, and known as "Group Health Association, Inc." Because of the special status of the HOLC, the opinion is viewed as purely advisory. However, the Association has requested the courts to adjudicate the matter. As yet, this important case has not been heard.

* * *

The Michigan Society for Mental Hygiene will meet at the Hotel Statler on April 7 and 8. There will be a special meeting on April 7 to which the medical profession are cordially invited. This meeting will be addressed by Dr. Harry Stack Sullivan of New York City. He is a member of the faculty of the Washington, D. C., School of Psychiatrists and president of the William A. White Psychiatric Foundation, New York. Dr. Sullivan's subject will be "The Application of Principles of Mental Hygiene to the Practice of Medicine."

Under the Crippled and Afflicted Child Laws, what fee is paid to physicians for calls made on hospital cases after the fifteenth day limitation has expired (such as for appendectomies)?

Answer: A fee of $1.50 per day, after the fifteenth day limitation, is paid to the physician who makes a call or calls on the patient in the hospital. Please note that the physician who calls at the hospital once a day is paid $1.50; if it is necessary for him to call two, three or more times the same day, he is paid $1.50 per *day*—not per call.

* * *

The American Board of Ophthalmology announces that it will hold examinations during 1938 in the following cities: San Francisco, June 13, during the A.M.A. Convention; in Washington, D. C., October 8, during the meeting of the American Academy of O. and O.L.; in Oklahoma City, November 14, during the meeting of the Southern Medical Association.

Any graduate or undergraduate of an approved medical school may make application for membership in this group Application blanks may be secured from Dr. John Green, Secretary, 3720 Washington Avenue, St. Louis, Mo.

* * *

The "sleeping potions" of an earlier day were often linked with evil doing, and plants having hypnotic powers were regarded with superstitious fear. Shakespeare mentions the shriek which was said to emanate from the mandrake (mandragora officinarum) as its roots were torn from the earth and which caused all mortals who heard to run mad. Hypnotic drugs, now thoroughly understood, have become an integral part of modern therapy. Quiet, restful sleep is procurable through the use of "Amytal" (Iso-amyl Ethyl Barbituric Acid, Lilly), and the drug is given with a feeling of safety based upon its broad background of clinical use.

* * *

Dr. C. E. Umphrey, President of the Wayne County Medical Society, has developed a new and very attractive format for his President's Monthly Letter. This four-leaved message contains timely notes on pertinent topics, and keeps the W.C.M.S. members informed of activities which are personal and confidential between physicians. President Umphrey's letters contain important information, attractively prepared.

"Everything you do to help the medical society, you do to help yourself," is one of the pithy statements in Dr. Umphrey's letter of February, 1938.

* * *

The Ingham County Medical Society will hold its Annual Spring Clinic on April 28, 1938, at the Olds Hotel, Lansing. Speakers of national eminence will be heard on the afternoon and evening programs. Among them are Dr. James M. Pierce of Cincinnati; Dr. Frederick Christopher of Evanston; Dr. H. G. Poncher of Chicago, and Dr. Frederick A. Coller of Ann Arbor. The afternoon session will begin promptly at 2:00 p.m. and dinner will be served at 7:00 p.m. followed by the evening lecture. All members of the Michigan State Medical Society are cordially invited to attend this one-day clinic.

* * *

Help W.P.A. pay you promptly.—It is the aim of the United States Employees' Compensation Commission and of the Michigan Works Progress Administration to make payment of vouchers for medical treatment rendered to injured W.P.A. employees with as little delay as possible. Physicians are urged to help W.P.A. officials in their attempt to help the physicians by having readily available full

information regarding treatment so that time consumed in the preparation of necessary medical reports and vouchers will be minimized. Be sure to keep accurate records—for your own protection. The above applies to compensation work only.

* * *

Michigan State Medical Society Placement Service.—The following communities desire a Doctor of Medicine, according to requests addressed to the Michigan State Medical Society:

Town	County	Size (Census in 1930)
Coral	Montcalm	350
Three Oaks	Berrien	1,336
Carsonville	Sanilac	444
Lawton	Van Buren	1,164
Argyle	Sanilac	200
Gladwin	Gladwin	1,248
Rose City	Ogemaw	338
Mio	Oscoda	350
Onondaga	Ingham	220

* * *

Under a system of socialized medicine, the patient will lose the advantages of the confidential patient-family physician relationship wherein the individual needs of every person are recognized. If ever a human being wants to be an individual, it is when he is sick!

The patient knows that free choice of physician must be restricted under a program of socialized medicine, as the leading physicians with more independence will not become part of a socialized medicine scheme. This has been the experience abroad. Medical attention will become a mechanical system rather than a personal service. Mass production methods will be used.

The patient does not want inferior *quality* of medical service.

* * *

Listed below are the names of some more of your friends who entered technical exhibits at the Grand Rapids Convention of the Michigan State Medical Society in 1937. The products of these firms are Council approved, where indicated, and are worthy of your consideration:

M & R Dietetic Laboratories, Inc., Columbus, Ohio.
McIntosh Electrical Corporation, Chicago, Illinois.
Mead Johnson & Company, Inc., Evansville, Indiana.
Medical Arts Surgical Supply Co., Grand Rapids, Michigan.
Medical Case History Bureau, New York City.
The Medical Protective Company, Wheaton, Illinois.
Merck & Co., Inc., Rahway, New Jersey.
The Wm. S. Merrell Company, Cincinnati, Ohio.
Michigan Branch, American Pharmaceutical Association, Dertoit, Michigan.
Middlewest Instrument Company, Chicago, Ill.

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Dr. Loren W. Shaffer, chairman of the Syphilis Control Committee of the Michigan State Medical Society, has arranged, through the Joint Committee on Health Education, to visit every county medical society in the Upper Peninsula during the last week of March. Dr. Shaffer will present the pertinent facts of the syphilis control program of the Michigan State Medical Society in coöperation with the State Department of Health to practicing physicians and to health officers. He will be accompanied by Dr. Clare Gates, Field Secretary of the Joint Committee on Health Education, who will contact and speak to many lay agencies along the route of some sixteen hundred miles.

The itinerary is as follows:

Monday, March 28—Manistique and Escanaba (noon and night); Tuesday, March 29—Menominee and Iron Mountain (noon and night); Wednesday, March 30—Ironwood and Houghton (noon and night); Thursday, March 31—Ontonagon and Marquette (noon and night); Friday, April 1—Newberry and Sault Ste. Marie (noon and night).

Secretary of State George E. Saunders of Colorado has ruled that the initiative petition for an amendment to the constitution of Colorado developed and circulated by chiropractors is invalid for submission to the voters of the state at the coming election. The proposed amendment, if adopted, would have repealed the Basic Science Law, and made the Medical Practice Act ineffective, as well as most public health laws. In short, it would have taken away from the state the right to license any profession, which has been interpreted by competent lawyers to include law, medicine, dentistry, nursing, accountancy, engineering, architecture, optometry, pharmacy, veterinary medicine, etc., ad infinitum.

The decision of Secretary of State George E. Saunders was based on evidence obtained by the Colorado State Medical Society.

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Pre-nuptial physical examination legislation: (a) The Ohio State Medical Association, in coöperation with the Ohio Bar Association, has developed a pre-nuptial physical examination bill, similar to the Michigan law, for presentation to the Ohio legislature at its next regular session.

(b) The Conference of County Society Legislative Chairmen of the Medical Society of the State of New York, meeting in Albany on February 9, approved the Pre-nuptial Physical Examination Bill now being considered by the New York Assembly.

(c) At the Indiana State Medical Society Secretaries' Conference in Chicago, February 12, Chairman A. M. Mitchell of Terra Haute advised that the Indiana State Medical Association is developing a pre-nuptial physical examination law for presentation to the Indiana legislature in 1939.

* * *

The gratitude of the medical profession and of the people of this state and country, is due the United States Congressional sub-committee which recently held hearings on the anti-vivisection bill (H.R. 3890).

The sub-committee decided to make an adverse report to the full Committee on the District of Columbia, which means that there is little chance of this pernicious measure being enacted into law by the present Congress of the United States.

Congressman Paul W. Shafer of the Third District of Michigan, whose residence is in Battle Creek, was an important member of this committee which felt that medical research would be retarded, if not destroyed, by enactment of any such measure as H.R. 3890.

Congratulations, Mr. Shafer, and thanks from a grateful public.

* * *

Kent County's "State Society Night"

A "State Society Night" was arranged by the Kent County Medical Society on February 9, in the Pantlind Hotel, Grand Rapids. The following State Society Officers were present: President Henry Cook, President-Elect Henry A. Luce, Secretary L. Fernald Foster, Treasurer Wm. A. Hyland, Councilors P. R. Urmston, A. S. Brunk, Vernor M. Moore, Henry R. Carstens, I. W. Greene, Past Speaker of the House Frank E. Reeder.

Brief addresses were given by Secretary Foster, Executive Secretary Burns, President-Elect Luce, President Cook, Finance Chairman Carstens, and by State Health Commissioner Don W. Gudakunst.

Arrangements were made by President A. J. Baker, Secretary John M. Whalen and Councilor Moore of the Kent County Medical Society. Over one hundred members of the Kent County Medical Society attended this very interesting and inspiring meeting.

Crippled and Afflicted Child Commitments for the months of December, 1937, and January, 1938, were as follows:

December, 1937

Crippled Child: Total of 228, of which 105 went to University Hospital, and 123 to miscellaneous hospitals. Of the above, Wayne County wrote 28 orders, of which two went to University Hospital and twenty-six went to miscellaneous hospitals.

Afflicted Child: Total of 1,477 of which 177 went to University Hospital, and 1,300 went to miscellaneous hospitals. Of the above, 312 were sent from Wayne County, of which nineteen went to University Hospital, and 293 went to miscellaneous hospitals.

January, 1938

Crippled Child: Total of 312, of which eighty-three went to University Hospital, and 229 went to miscellaneous hospitals. Of the above, Wayne County wrote 118 orders; five went to University Hospital and 113 went to miscellaneous hospitals.

Afflicted Child: Total cases, 1,498 of which 223 went to University Hospital, and 1,275 went to miscellaneous hospitals. Of the above 434 were sent from Wayne County, twenty-four going to University Hospital, and 410 to miscellaneous hospitals.

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The Northern Tri-State Medical Association

The Northern Tri-State Medical Association will hold its sixty-fifth annual meeting April 12, 1938, at Findlay, Ohio. The program is as follows: Dr. H. H. Cummings, Obstetrician and Gynecologist of Ann Arbor, Michigan, "Treatment of Fibromyoma of the Uterus"; Dr. Warren H. Cole, Professor of Surgery, University of Illinois, "Hyperthyroidism"; Dr. Douglas Donald, Assistant Professor of Clinical Medicine, Wayne University, Detroit, "Pain in the Cardiac Area Not Due to Coronary Disease"; Dr. Charles Doan, Professor of Medicine, O. S. U., Columbus, Ohio, "The Myelophthisic Anemias"; Dr. Max Thorek, Surgeon, Chicago, Illinois, "Electrosurgical Obliteration of the Gall Bladder"; Dr. Irvin S. Cutter, Dean, Northwestern University Medical School, Chicago, "Therapeutics of Later Years of Life"; Dr. Daniel J. Davies, Assistant Professor of Obstetrics, University of Cincinnati, Ohio, "Hemorrhage in Pregnancy and Labor"; Dr. B. H. Nichols, Roentgenologist, Crile Clinic, Cleveland, Ohio, "Evaluation of X-ray Findings in Diseases of the Stomach and Gall Bladder"; Dr. Max Cutler of Michael Reese Hospital, Chicago, Illinois, "Indications and Limitations of Radiation in the Treatment of Cancer", and Dr. J. S. Speed, Professor of Orthopedics, University of Tennessee, "Central Fractures of the Neck of the Femur."

In the evening, there will be a banquet. The speakers will be Dr. Gilbert J. Thomas, President of the American Urological Association, Minneapolis, "Infections Other than Tuberculosis of the Urinary Tract: Diagnosis and Treatment," and Dr. Alan Brown, Professor of Pediatrics, University of Toronto, Ont., Canadian Gov., Consultant for Quintuplets, "A Consideration of Some Common Disturbances in Children Frequently Incorrectly Handled."

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Medical Education
Herman Kiefer Hospital, Detroit

Since 1930 Graduate Conferences for Physicians have been sponsored in Detroit jointly by the Wayne County Medical Society and the Detroit Department of Health. During this period there have been sixty-eight conferences, forty-three individual speakers and a total attendance of approximately 7,500. These conferences were devoted almost entirely to Preven-

tive Medicine, and attendance at these meetings definitely indicates their value and the interest of the private physician in this field. In addition to these bi-annual conferences there are many other well-attended meetings held throughout the city every year devoted largely to Preventive Medicine.

1938 GRADUATE CONFERENCE FOR PHYSICIANS
Herman Kiefer Hospital Auditorium
Detroit
Month of April Wednesday Mornings 10 to 12 o'clock
ALL PHYSICIANS ARE INVITED

April 6
10 A. M. "The Practicing Physician and Syphilis Control and Treatment"—Dr. John H. Stokes, University of Pennsylvania.
11 A. M. "Present Therapeutic Problems in the Control of Gonorrhea"—Dr. P. S. Pelouze, University of Pennsylvania.

April 13
10 A. M. "Pneumonia Control"—Dr. Jesse G. M. Bullowa, New York City.
11 A. M. "Serum Sickness"—Dr. Warren T. Vaughan, Richmond, Va.

April 20
10 A. M. "Evaluation of Present Immunization Methods"—Dr. LeRoy D. Fothergill, Harvard University.
11 A. M. "New Concepts and Developments of Treatment of Communicable Disease"—Dr. Edwin H. Place, City Hospital, Boston, Mass.

April 27
10 A. M. "The Mental Problems of the Adolescent"—Dr. William S. Sadler, Chicago, Ill.
11 A. M. "The Recognition and Treatment of the Early Case of Mental Illness"—Dr. Winfred Overholser, St. Elizabeth's Hospital, Washington, D. C.

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Jackson County's "State Society Night"

The Jackson County Medical Society, originator of Michigan's "State Society Nights," held its third annual event of this type on January 18, 1938, at the Hotel Hayes. The cocktail hour started at 5:30 P.M. and dinner was served in the ballroom promptly at 7:00 P.M.

The meeting was called to order by the president, Dr. John VanSchoick of Hanover, whose address of welcome was supplemented by similar remarks from Dr. A. W. Strom, vice president of the Hillsdale County Medical Society who joined the Jackson group this year as co-hosts for the evening.

Dr. H. H. Cummings of Ann Arbor, councilor of the 14th district, spoke on "Post-graduate Medicine." Dr. Martin H. Hoffmann of Eloise, vice speaker of the House of Delegates and chairman of the State Society membership Committee discussed "Much Ado About Something." Dr. Henry Cook of Flint, president of the M.S.M.S., spoke on "The Professional Background." Dr. A. G. Sheets, mayor of Eaton Rapids, and his inseparable companion, Dr. J. G. Bradley of Eaton Rapids, advisor to the Legislative Committee of the M.S.M.S., spoke extemporaneously. Dr. J. E. McIntyre of Lansing and Dr. Wilfrid Haughey of Battle Creek, councilors of the 2nd and 3rd districts respectively, made a few appropriate remarks.

The sergeant-at-Arms of the House of Delegates of the M.S.M.S., Dr. James John O'Meara, paid a very glowing tribute to the work of one of the Jackson members and then introduced this member who, strange as it may seem, turned out to be his brother-in-law, Dr. Philip A. Riley, who seems to have survived the relationship enough to have become Speaker of the M.S.M.S House of Delegates in spite of this tremendous handicap. Dr. Riley gave a résumé of the work accomplished at the recent meeting of The Council of the M.S.M.S. in Detroit and the high lights of the plans for 1938.

Dr. W. L. Finton had the pleasure of introducing his son, Dr. Walter R. Finton, to the group at the young doctor's first meeting as a regular member of the society. This makes the second father-son combination at Jackson, the other being Dr. John C. Smith and his son, Dr. Dean Smith, who became a member last summer.

Telegrams of regrets were read by the secretary from Bill Burns (ill in the hospital), Drs. L. F. Foster, Grover C. Penberthy, Henry A. Luce and others.

The attendance from the two societies acting as hosts was nearly 100 per cent and a fine evening of friendship was enjoyed.

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How to go to San Francisco Next June.—Special trains and cruises to San Francisco for the 1938 meeting of the American Medical Association are being arranged, for the convenience of physicians and their ladies who plan on attending the Convention, June 13 to 17, 1938. We invite your attention to:

1. **The "Golfers Special"** of the American Medical Golfing Association, which includes an ocean voyage from New York to New Orleans (six days) on the S. S. Dixie, sailing June 1. Five games of golf will be played on excellent courses on the out-going trip, with stops and sightseeing at Houston, Galveston, San Antonio, Los Angeles, and Del Monte.

The big A.M.G.A. Tournament will be held at the San Francisco Golf and Country Club on Monday, June 13. (36-hole competition).

The return journey will be through Portland, Seattle, Vancouver, Lake Louise and Banff, with two additional games of golf, more sight-seeing, and a steamship voyage up Puget Sound.

Non-golfers as well as golfers (and their ladies) are invited to take advantage of this unique trip.

Those not able to make the entire trip may take the "Golfers Special" on the out-going trip, or join it on the return journey. For further information write Bill Burns, 731 N. Capitol Avenue, Lansing, Michigan. (See announcement in this issue on page 291).

2. **The American Express Tour** starts officially in Chicago on June 6, and includes an exploration of the Indian Pueblo district, the Grand Canyon, Los Angeles, Riverside and Santa Catalina Island, on the way out to San Francisco. A choice of two return routes is possible, one of which visits the charming cities of Portland, Seattle, Victoria, Vancouver and the beautiful scenic pots of the Canadian Rockies; the second route, traveling through Yellowstone National Park (three and one-half days), and via Salt Lake City, Royal Gorge, Colorado Springs and Denver. For complete details write the American Express Travel Service, 723 Marquette Avenue, Minneapolis, Minn.

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American College of Surgeons

The Great Lakes Sectional Meeting of the American College of Surgeons, including Ontario, Quebec, and the states of New York, Ohio, Michigan, and Pennsylvania, will be held in Toronto, Ontario, on March 22, 23, and 24. The headquarters will be at the Royal York Hotel. A most active Committee on Local Arrangements, headed by Dr. W. Edward Gallie, is making excellent plans for this meeting. There will be an exceptionally interesting program consisting of clinics, scientific sessions, hospital conferences, medical motion pictures, and other features during the meeting. A visiting group of ten or twelve outstanding surgeons will be present to participate in this program.

A general outline of the program is as follows:

Tuesday, March 22

8:00- 9:00—Registration and general information for Fellows of the College, hospital representatives, and guests.
9:00-12:00—Operative and non-operative clinics, surgery and the surgical specialties, local hospitals.
10:00-12:30—Hospital conference.
2:00- 4:30—Hospital conference.
2:30- 4:30—Medical motion pictures:
1. General surgery.
2. Eye, ear, nose and throat surgery.
4:30- 5:00—Annual meeting, Fellows of the College.
6:30- 8:00—Medical motion pictures, general surgery.
8:00-10:00—Scientific meeting, general surgery.
8:00-10:00—Medical motion pictures, eye, ear, nose and throat surgery.
8:00-10:00—Hospital conference.

Wednesday, March 23

8:00- 9:00—Registration and general information for Fellows of the College, hospital representatives, and guests.
9:00-12:00—Operative and non-operative clinics, surgery and the surgical specialties, local hospitals.
10:00-12:30—Hospital conference.
1:00- 2:00—Medical motion pictures, general surgery.
2:00- 5:00—Scientific meeting, general surgery.
2:00- 5:00—Scientific meeting, eye surgery.
2:00- 5:00—Scientific meeting, ear, nose and throat surgery.
2:00- 5:00—Hospital conference.
6:30- 8:00—Medical motion pictures, general surgery.
8:00-10:00—Scientific meeting, general surgery.
8:00-10:00—Scientific meeting, eye surgery.
8:00-10:00—Scientific meeting, ear, nose and throat surgery.
8:00-10:00—Motion pictures for hospital representatives.

Thursday, March 24

8:00- 9:00—Registration and general information for Fellows of the College, hospital representatives, and guests.
9:00-12:00—Fracture clinic.
9:00-12:00—Operative clinics, eye, ear, nose and throat surgery.
10:00-12:30—Hospital conference.
2:00- 5:00—Scientific meeting (panel round table conference), eye surgery.
2:00- 5:00—Scientific meeting (panel round table conference), ear, nose and throat surgery.
2:00- 5:00—Cancer clinic.
2:00- 5:00—Hospital conference.
8:00-10:00—Medical motion pictures, general surgery.
8:00-10:00—Community health meeting.

This meeting will be of interest not only to Fellows of the College but to the medical profession at large, as well as to hospital trustees, superintendents, nurses, and hospital personnel. Members of the State Medical Association are most cordially invited to attend. There will be no registration fee.

German Baby Ban

The Nazi government, still determined to build a nation of physically superior citizens regardless of the cost, has instructed doctors that deformed or abnormal babies are not to be brought into the world. Strange as it sounds, reports come from extremely reliable sources that the German Health Ministry has issued a short, confidential memorandum to this effect to all practicing doctors. The memo added: "As a medical man, you will know how to prevent the child taking life, and what to explain to the mother."—*News Week*, Feb. 21, 1938.

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All communications relative to exchanges, books for review, manuscripts, should be addressed to J. H. Dempster, M.D., 5761 Stanton Avenue, Detroit, Michigan.

All communications regarding advertising and subscriptions should be addressed to William J. Burns, LL.B., Executive Secretary, 2642 University Avenue, St. Paul, Minnesota, or 2020 Olds Tower, Lansing, Michigan. Telephone 5-7125.

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Manuscripts should be typewritten, double spaced, on one side of white paper 8½x11 inches. There should be a margin of 1½ inches on the left side of page. Do not send carbon copies; always submit the original typescript.

All photographs as illustrations should be clearly focused prints on glossy paper (do *not* send negatives). The standard 8x10 or 5x7 size prints are recommended.

All line drawings (charts, diagrams and sketches) are to be drawn with India ink on stiff white paper or Bristol board. Drawings are to be made with pen lines of suitable thickness to allow reduction to the width of one or two columns, as the case may be, of THE JOURNAL. Do *not* send drawings in colored ink.

Illustrations will not be accepted unless they reach a certain standard of excellence technically and present an attractive appearance. Illustrations, both photographs and drawings, are to be separate from the text. Each should be labeled on the back with the figure number, legend, title of paper and the author's name.

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